

1991

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Hunt, L. (1991). *Professional experience programme report: women's health promotion, an international perspective*. Claremont, Australia: Centre for the Development of Human Resources, Edith Cowan University.
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Centre for the Development of Human Resources

PROFESSIONAL EXPERIENCE PROGRAMME REPORT

Women's Health Promotion, an International Perspective

Lynne Hunt

February 1991
Technical Report No. 26
ISSN 1036-319X
ISBN 7298-0097-0



EDITH COWAN
UNIVERSITY

PERTH WESTERN AUSTRALIA

PROFESSIONAL EXPERIENCE PROGRAMME REPORT.

WOMEN'S HEALTH PROMOTION,

AN INTERNATIONAL PERSPECTIVE



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ACKNOWLEDGEMENTS

I should like to thank the School of Community and Language Studies and Edith Cowan University (formerly the Western Australian College of Advanced Education) for the opportunity to undertake a Professional Experience Programme in 1988-89. I thank also all the women who gave so freely of their time to discuss with me their work in the area of women's health. The hospitality of many friends and relations in Australia, USA, Canada, Britain, Ireland and Norway facilitated the study. Finally, thanks go to Ms Suena Haunold and Ms Toni Lampard for their patient work in typing the manuscript and to Dr Vivienne Waddell and Associate Professor Lyall Hunt for their editorial comments.

The ideas and conclusions in this report are those of the writer and may not necessarily represent the views of Edith Cowan University or the agencies contacted during the study.

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SECTION 1

THE SCOPE OF THE PROFESSIONAL EXPERIENCE PROGRAMME

THE SCOPE OF THE PROFESSIONAL EXPERIENCE PROGRAMME

Between August 1988 and January 1989 I visited nine countries in the Western Pacific, North America and Europe to survey women's health promotion from the perspective of the women's health movement. The experience was facilitated by study leave (Professional Experience Programme) from the Western Australian College of Advanced Education (now Edith Cowan University).

The main purpose of the study was to exchange ideas with selected academics and experts in women's health. The information acquired will be applied in courses in women's health offered by Edith Cowan University and in the ongoing development of a series of videotape productions on women's health issues. (See Appendix 1).

Specifically, the objectives of the study tour were to:

1. explore the open use of the media for women's health promotion;
2. target a variety of issues in major cities to gain an international and comparative perspective on women's health promotion;
3. introduce, to national and international organizations, a series of videotapes on women's health developed under my direction at Edith Cowan University.

Nine developed countries were visited: Australia, New Zealand, U.S.A., Canada, England, Ireland, Holland, Denmark and Norway. The Professional Experience Programme was planned on the basis of a minimum of one and a maximum of two interviews per day. These interviews were open-ended. In general, the agency representatives raised issues vital in their local setting. The early interviews set the agenda for the whole study because some issues emerged repeatedly. These topics, subsequently explored in all settings, included:

1. the extent to which women's health services should be mainstreamed;
2. the advantages and disadvantages of collective organization;
3. the importance of self-care and self-help;
4. the extent to which services should be separately organized for special need groups;
5. the importance of developing and making accessible health information for women;
6. the significance of ideology in the women's health movement;
7. the treatment of women by the medical profession, both in service delivery and in research programmes;
8. the need for social action;

9. the relationship between women's health groups and professionals;
10. the impact of the broader socio-economic and political context on women's health groups, particularly in the provision of funding.

In all 71 agencies were visited. (For a complete listing see Appendix 2). They varied from very small collectives, through established women's health clinics to government authorities and included: health promotion groups; health care groups; social action groups; government departments; research centres; academic units teaching women's health; international organisations including W.H.O.; and feminist journals and media groups. The majority of the agencies visited were clearly identified with the women's health movement. The views expressed in this report, therefore, are informed by the perspectives of that movement. Although some hospitals were studied, they were generally selected for their innovative work in response to the demands of the women's health movement. This is not, therefore, an account of the contributions made to women's health promotion by doctors and nurses working within the mainstream medical services.

The agencies were chosen to elucidate information on specific topics: migrant and indigenous women's health; social policy; women's health organizations; women's health promotion (in particular the use of the media for health promotion); home-birth; abortion; occupational health; social action; research and the teaching of women's health issues in tertiary institutions. An extensive range of issues is raised in this report. They represent the concerns of the women's health movement as observed during this study programme. The issues discussed, therefore, are representative of the dominant themes in the women's health movement but they are not, nor could they be, an exhaustive list of all women's health concerns.

In adopting an international perspective on women's health issues, the temptation was to explore differences arising from socio-economic and political contexts. However, similarities emerged as being of equal importance, thus highlighting the universal nature of women's status and needs. Since there was so much commonality in the issues, this report is developed thematically. The agencies themselves are introduced when they highlight a theme.

The report is presented in considerable detail so that it may be used as a text in tertiary level studies of women's health issues. It is based not only on the verbal content of interviews but also on documentation acquired during the tour. In many cases the interviewees were the authors of the written material.

SECTION 2

WOMEN'S HEALTH AND IDEOLOGY

WOMEN'S HEALTH AND IDEOLOGY

THE PARAMETERS OF THE WOMEN'S HEALTH MOVEMENT

The modern, women's health movement is a product of the second wave of feminism which emerged in the 1960s. Women's bodies and well-being quickly became a focus of concern because

body education is core education. Our bodies are the physical bases from which we move out into the world; ignorance, uncertainty - even, at worst, shame - about our physical selves creates in us an alienation from ourselves that keeps us from being the whole people that we could be. (Boston Women's Health Book Collective, 1971:3).

The centrality of health in the women's movement also reflected a need to improve understanding of the body in order to debate "that biology is destiny" - an argument which has been used to exclude women from some spheres of activity. Moreover, health issues were becoming more significant in society at large. Indeed, Daniel Bell (1973) predicted that in post-industrial society the older class conflicts would be replaced by a concern for services such as health.

The reference point of the women's health movement is a past in which women were the primary health care givers. (See Ehrenreich and English, 1979). Its goal is the empowerment of women. Specifically, the demands of the women's health movement have included: good access to health information; the development of personal skills in self-care; changes in the social circumstances of women to promote wellness; an emphasis on prevention rather than cure; a greater choice of health care delivery systems; and changes within medical services. Pascall (1986:167) has successfully summarized the parameters of the women's health movement:

The Women's Health Movement is a varied and changing constellation of groups. The common purpose has been to challenge medicine's control of reproduction, and to assert the claims of women to knowledge and power over their own bodies. The point is not to go 'back to nature'. It is rather to argue that medicine has usurped knowledge that is particularly useful to women ... has made it less available; and has reduced women's power over their own lives. It is also claimed that medicine's narrow approach to women's health problems contradicts women's experiences, with the result that it is often unhelpful or even damaging.

WOMEN'S HEALTH AS A SOCIAL MOVEMENT

The women's health movement is organized locally, nationally and internationally through networks of individuals and organizations. It is a social movement.

The notion of a social movement as a collection of persons acting to bring about consciously willed social innovation entails that its ideology be examined step

by step in relation to the circumstances it faces throughout its history and to the interplay of the actors in the role network which comprises the structure of the movement as a viable collectivity. From this point of view a social movement has not one ideology but many, at different points in time and by reference to the various groups of which it is composed and the various publics to which it addresses its appeal. (Banks 1972:40)

THE IDEOLOGIES OF THE WOMEN'S HEALTH MOVEMENT

Ideology may be defined as a "set of definitions of reality legitimating specific vested interests in society." (Berger and Kellner 1981:70) The women's health movement reflects three specific ideologies: feminism, empowerment and the social model of health. All are similar in their humanitarianism and goal of liberating individuals from the constraints of traditional role expectations and power relationships.

FEMINISM

Feminism represents a viewpoint which has emerged from a "continuous history of feminist thought, traceable at least to the fifteenth century." (Eisenstein 1979:xiii) It is an "analysis of women's subordination for the purpose of figuring out how to change it." (Gordon quoted in Eisenstein 1979:107)

Following early twentieth century initiatives by the suffragette movement, the second wave of feminism began in the 1960s. At that time feminist thought was guided by Simone de Beauvoir's The Second Sex and Betty Friedan's The Feminine Mystique. Both women explored the social construction of gender roles as the source of women's oppression.

A solution was seen in the concept of androgyny which sought to replace gender polarization by an increasing fusion of female and male roles. This, however, implied social change by individual transformation - a perspective criticized by socialist/Marxist feminists because it ignored the structural origins of gender roles.

Liberal feminists have sought to make women more successful within the prevailing patriarchal structures of society. Much of this work, in Australia, has been done under the guise of government sponsored affirmative action legislation. However, more recently, women have been seeking a new woman-centred perspective "to define those aspects of female experience that [are] potential sources of strength and power for women, and, more broadly, a new blueprint for social change." (Eisenstein 1979:xii)

So much has a woman-centred perspective gained ground that "now, in the mid-eighties, it is practically impossible to speak of 'male feminism'. Feminism is increasingly understood by feminists as a way of thinking created by, for and on behalf of women, as gender specific." (Delmar in Mitchell and Oakley 1986 :27)

Banks (1972:40) argued that ideologies change in accordance with the historically specific circumstances of groups. It should, therefore, be no surprise to find that there are many branches of feminist thought. Colonialism, capitalism and racism dissect feminism so that, for example, women of colour develop ideologies which are distinct from those of their white sisters. Similarly, middle class and working class women vary in their priorities. Even working class women in the western world would be seen as privileged by third world women. So it is that any attempt to define feminism narrowly would ignore the variety of women's experience:

feminist stress on women's socially constructed 'difference' from men can go along with recognition of diversity among women themselves, if we acknowledge the multifaceted entity - the patchwork quilt, so to speak - that is called women. That acknowledgement allows coalition building, the only realistic political 'unity' women have had or will have. (Cott in Mitchell and Oakley 1986:59).

At the beginning of the 1990s three basic feminist traditions can be identified: liberal, radical and socialist/Marxist. In health terms their demands differ in emphasis but not in intent. Liberal feminists focus on equal access to health care for women, without necessarily stressing any major changes in the system of health care delivery. Socialist feminists also seek equality but demand changes in the system through the welfare state and nationalized health services. Radical feminists question conventional medical care and support the creation of alternative care and self-help.

In intent, the differing feminist perspectives share the common goal of improving the situation of women which at the minimum requires:

1. the opportunity to participate in public life;
2. sexual and reproductive freedom, for example, contraception, abortion and freedom in sexual preference; and
3. an end to sexual harassment, rape and physical abuse.

What is important is the freedom inherent in ideological difference because, in the final analysis, feminism is about freedom of choice. It would, therefore, be a contradiction to impose an ideological straight-jacket on the development of the women's health movement. The need for diversity is now well established. In 1971, for example, the Boston Women's Health Book Collective (p.2) addressed this issue:

Many women have spoken for themselves in this book, though we in the collective do not agree with all that has been written. Some of us are even uncomfortable with part of the material. We have included it anyway, because we give more weight to accepting that we differ than our uneasiness.

There is a point, though, at which feminism must impose its own constraints - when being "P.C." (politically correct) becomes an issue. If a central feature of a feminist women's health movement is choice, then the limits to ideology exclude the perspective of those women who work to deny choice in, for example, the right to abortion.

WOMEN'S HEALTH AND EMPOWERMENT

The second dominant ideology in the women's health movement is empowerment, a philosophy which encompasses both individual and social change. The individual dimension

begins with the recognition that something is wrong with society... In an empowerment approach, individuals come to recognise their inadequacies as the effects of an unfair system... At the same time, this discriminating aspect of society comes to be seen as changeable by the individual, together with others from the same group. (Fletcher 1988:4-5)

An encompassing definition of empowerment may be found in a report of the Youth Affairs Council of Australia (1983:21) which emphasized that all dimensions of the model must be kept in balance:

This approach to empowerment embraces the need for the creation of new forms of social organization, the development of knowledge and skills and access to the accumulation of productive assets. It places priority upon the social and political organization of [women] because this is seen as the necessary means of achieving greater access to and control over other socio-economic resources (or, 'bases of power'). Friedmann has identified the bases for the accumulation of social power as 'productive assets' (land, finance, equipment, buildings, your health); 'financial resources' (your income and credit worthiness); 'social and political organization' that will advance your interests along with those of your sisters and brothers (political parties, syndicates, co-operatives, mutual aid societies); 'social networks' to link with and to get things done, to find things out, 'appropriate knowledge and skills'; and, 'information' for advancing your life chances.

In summary the empowerment model incorporates:

1. the development of new forms of organization
2. the development of resources, knowledge and skills
3. improved access to resources and information
4. social and political action.

THE SOCIAL MODEL OF HEALTH

The third ideology of the women's health movement is the social model of health. In order to trace the historical path to this perception of health it is useful to develop an ideal-type continuum which moves from a traditional model of health care, through the medical model to the social model.

Before the advent of a scientifically based medical profession, communities took care of their own health. Often specialist care-givers did emerge:

Ostensibly the traditional healer's principle task was to treat illness. But anthropologists have shown that this was only one of a broad range of functions: the healer was not only physician but also counsellor, religious adviser, judge and entertainer. (Russell and Schofield 1986:8)

This combination of tasks is not surprising in societies which perceived a connection between social, biological and supernatural issues. The approach was holistic: "specific syndromes are recognised and frequently dealt with, but are not separate from the total disease of the patient, her family and her society." (Wood 1979:306)

Within the traditional view of medicine many problems were dealt with without recourse to an expert: "Common childhood disorders and other conditions defined, because of their prevalence or some other cultural factor, as minor or 'natural', [were] treated with widely available herbal and other remedies, usually by women." (Wood 1979:309) As society changed to more sedentary agricultural communities and then to industrial, urban society there was a noticeable trend to increased specialization: "Healing is no exception: more categories of healers appear...". (Russell and Schofield 1986:10) The important point is that, "In any society, the form taken by medical care (its practices) is, naturally, closely linked with beliefs about the nature and cause of illness." (Russell and Schofield 1986:11)

The modern medical model, with a reliance on experts, is a relatively recent phenomenon. Even in the twentieth century, among rural pioneers in Australia, there was little alternative to self-health remedies and neighbourly assistance. However, today, major health expenditure is linked to the delivery of health services dominated by professionals whose pre-eminent role in society has ousted the traditional care-givers: "the expert's authority rested on the denial or destruction of...autonomous sources of knowledge: the old networks of skill-sharing, the accumulated lore of generations of mothers." (Ehrenreich and English 1979:4)

A leading critic of modern health care delivery systems, Ivan Illich (1976:220), noted that the development of health care as a commodity, for which we must pay, not only resulted in "over expansion in the health care industry" but also thwarted the power of people to respond to challenges and to cope with changes in their bodies or in their environment.

The modern medical perception is "a mechanistic one, in which the body is treated like a machine which occasionally malfunctions. This approach emerged during the scientific revolution." (Russell and Schofield 1986:131) Thus the very nature of science may itself be partly responsible for the move from a holistic to a mechanistic view of medical care. Personal perceptions and feelings, for example, are not the stuff from which scientific conclusions can be drawn. Indeed, one British study on the safety of oral contraceptives noted that women's own evidence on headaches and lack of libido was "too subjective to be assessed." (Roberts 1985:8)

Russell and Schofield (1986) identify the three main characteristics of the medical model as being: cure focussed; individualistic in orientation; and interventionist in nature. The emphasis on cure rather than prevention is evident in the data on health expenditure in Australia where as little as 5% of health monies are spent on prevention. (Goldstein 1983:58) Russell and Schofield (1986:134-135) outline the dimensions of the individualistic orientation of the medical model as follows:

The assumption that the cause of illness lies within the malfunctioning bodies of individuals is another key feature of the medical model...This is not to suggest that, particularly in recent years, the medical view has not come to identify the environment and living conditions as contributing to illness. However, this perception has been narrow and selective, focussing on those aspects of 'lifestyle' that are seen as being under the individual's control. The person is blamed for his or her own health - too much smoking, eating the wrong food, or not getting enough exercise. It is still the individual who is the focus of attention, not the social environment which constrains his or her choices.

The plethora of medical technology, surgical procedures and the use of powerful drugs are all symptomatic of the interventionist nature of medicine. Such intervention is, of course, welcomed when it is essential for the survival of a sick person, but it is the extent and mechanistic nature of the intervention that has led many to criticize the medical model. This critique has been a dominant theme of the women's health movement. Surgical intervention in the form of hysterectomies and caesarian sections have been seriously questioned, so has drug intervention such as the use of DES and Depo Provera.

The women's health movement has adopted a social model of health essentially because "women see a state of health as being achieved through consideration of the social, economic, cultural and psychological context of their complex lives as well as their biological needs." (Women's Health and Wellbeing: 1986) The social model of health emphasizes wellness which looks to social rather than individual determinants of health, it identifies health not only as freedom from illness but also as human fulfillment, self-discovery and the improvement alienating social circumstances. The solutions go beyond health education and promotion to preventive measures based on social change - in other words, social action.

The social action approach to wellness includes: consumerism; networking; legislative and political action with regard to such things as cigarette advertising; small group work in the area of self-care; and a commitment, at the international level, to causes such as the peace movement, since wellness is contingent on survival. The concept of wellness is a crystallization of a number of disparate influences which have emerged over recent years: Ivan Illich's Limits to Medicine; Nader's consumerism; heightened awareness of personal health issues; and the women's health movement.

In conclusion, the parameters of the women's health movement include feminism, empowerment and the social model of health. These strands of thought are similar and, as guides to action, include the need for de-professionalization, the spread of information, social action and new forms of organization.

APPLICATION OF IDEOLOGY IN THE WOMEN'S HEALTH MOVEMENT

In application, the three ideologies - feminism, empowerment and the social model of health - merge. Feminism is about the empowerment of women; and the social model of health is no more than an action plan for implementing empowerment philosophy within the health area. However, the application of these ideologies in hostile socio-economic, political and bureaucratic contexts emerged as a major concern of feminists during this study programme. A clear conclusion, drawn from observation, is that ideological purity is hard to sustain in service delivery settings. A second conclusion is that there is a need for a constant critique of ideology both to avoid the authoritarian imposition of a single, acceptable viewpoint and to evade the misuse of humanitarian philosophies.

Since feminist ideology is the *raison d'être* of the women's health movement, it is important for that ideology to remain strong in terms of setting the targets and goals of women's groups. It is also crucial to sustain feminist solidarity in the arena of social action - otherwise ideological diversity will be used to divide and rule. It is for this reason that the National Women's Health Network, in America, works so hard to create position papers which are based on consensus. (See, for example, its recent paper on hormone replacement therapy). What is less certain is how far a doctrinaire stance can be taken into service delivery. The problem is that the ideology, designed to liberate, can itself become an imposition. Take, for example, one clinic in North America in which the collective decided that women needed pre-abortion, group counselling. The women who are obliged to attend these sessions are also given the option of participating in post-abortion group meetings. Most vote with their feet by not attending. The decision to provide counselling was made in the light of the limited opportunities for such support within mainstream medical services. Whilst the provision of the service is laudatory, its imposition, especially in group sessions, is an example of taking ideological certainty too far into service delivery. The hidden agenda, "Thou shalt be empowered", seems to be a contradiction in terms.

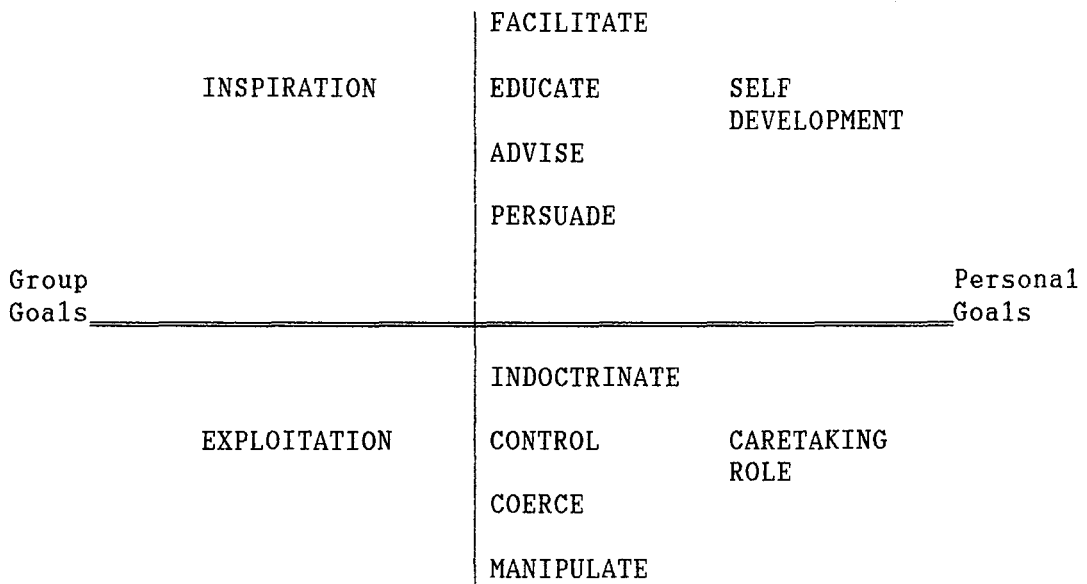
The issue is client empowerment. This makes it difficult for ideologically informed feminist collectives to work with women who view life differently. Consider the notice placed outside a New Zealand

women's health centre: "Please ring. Women come in. Men stay outside." Appropriate, perhaps, for a rape victim who prefers to deal only with women, but inappropriate for a heterosexual couple trying to work together on their own reproductive concerns. Fletcher (1988:7) believes that it is possible to hold to an empowering strategy while dealing with other people's values:

It is possible to hold to the empowerment approach and still act ethically. Those working in the women's programs... for example, manage to act on the basis that women are discriminated against, even though individual women who came into contact with the programs insist that it is not so.

Fletcher concludes that, whilst one cannot insist, it is also impossible to deny that personal problems are connected to social structure.

If client empowerment is not a central feature of the work of the women's health movement, then the issue of manipulation emerges: "The...criticism of the empowerment approach is that professionals who try to use empowerment are manipulating their target groups or the individuals they deal with, and imposing their own values onto others." (Fletcher 1988:7) To avoid manipulation, the key words for working with individuals and groups of women must be: facilitate, educate, advise and persuade, as illustrated in the model developed by Fellows (1986).



CONCLUSION

A major conclusion drawn from this study is that ideologies set the parameters and goals for decision-making rather than prescribing service delivery strategies. Within the context of the women's health movement the major goal emerging from feminism and the social model of health is client empowerment.

SECTION 3

NEW FORMS OF ORGANIZATION

NEW FORMS OF ORGANIZATION

In adopting the social model of health, the women's health movement is part of the wider critique of the medical model of health care: "The essential problem...is inappropriateness: it is claimed that women's health services have been inappropriately designed and delivered." (Davis and George 1988:295).

Professional hierarchies of entrenched power have not been able to adapt to consumer demands calling for "new forms of social and political organization...to provide essential passages to equality, justice and development." (Youth Affairs Council of Australia 1983:23) The consequence has been the development of a network of women's health organizations "separated from mainstream medicine and designed to educate women about their bodies and medical concerns, and to provide sensitive care." (Davis and George 1988:295)

WOMEN'S HEALTH CENTRES

The development of women's health care centres has become a central feature of the Australian women's health movement. By international standards, Australia is singularly well endowed with such centres. However, the number and type vary by State: The long history of a conservative political environment in Queensland mitigated against the development of a network of centres similar to those existing in South Australia. In Western Australia the Health Department has a Women's Health Policy Unit, which is developing a chain of women's health centres across the State. However, if Australia shines by international standards, this serves only to highlight how minimal are the specialist services for women on a world-wide basis because, of those centres which do exist, many are under-funded and have uncertain futures.

Women's health centres have also emerged in New Zealand, Ireland, U.S.A., Canada, England and Holland. They always emphasise new, empowering organizational forms - usually a collective or at least a flattened management structure.

McShane and Oliver (1987:617) identified the major differences between feminist and conventional organizational forms. Their summary is reproduced in the following table:

	Alternative Feminist Agency	Conventional Agency
Authority structure	Collegial/Collective	Hierarchical
Performance guides	Internalization of organizational goals/Feminist ideology	A-priori guides rules/White male ideology system
Problem-solving process	Collective decision-making	Bureaucratic
Planning process	Persons delegated by representatives of women	Experts
Public service model	Help women to advocate for selves	Maintain (status quo) system
Agency orientation towards women's problems	Preventative/Responsive	Curative/Reactive/Consumer pressure oriented
Pattern of relating to women	Humanistic/Personalised	Impersonal
Accountability	To consumers and collective	To taxpayers and agency administrators
Feelings and attitudes engendered in consumers by the agency	Belonging/Solidarity/Collective potency	Unwanted/individualism/Competitiveness/Personal impotence

In tone, women's health centres are relaxed, avoiding the formidable, cold atmosphere often associated with clinics and surgeries. Objectives range from health information and referral services, to well-woman centres which provide medical services. In general, the focus is on reproductive and gynaecological health, cancer screening and sexual assault counselling. Some centres focus on single issues such as mental health, an example being the Women's Clinic run by the Toronto Western Hospital, Department of Psychiatry. The philosophy of women's health centres may be summed up by what the Centre de Santé Des Femmes, in Montreal, calls their "3 D's": *démédicaliser*; *déprofessionnalisation* and *dèsexiser*.

Some groups calling themselves women's health centres are simply private enterprise clinics staffed by female general practitioners. Such centres are not typical of organizations which draw on the ideologies of feminism, empowerment and the social model of health which are distinguished by their commitment to holistic health care: Medical services are backed up by counselling; health information; naturopathy and resources such as child care. Many women's health centres sustain a commitment to social action and some, as in Plymouth, New England, specifically allocate the task of political action to one or more paid members of the collective.

It is part of the empowerment philosophy that, wherever possible, client and provider groups should be matched because: "our own race, class and background must influence our familiarity with different client groups and our skill in maintaining contact and dealing effectively with them." (Helean and Huygens 1986:194) Consequently, all women's centres observed were run by and for women. The needs based philosophy has been taken still further in the development of black/multicultural women's health centres as in Brixton, England, Toronto, Canada and Fremantle, Western Australia. Such centres are staffed by women drawn from local ethnic groups.

However, the extent to which separate organizations, catering for distinct needs, should develop was viewed as problematic by some women's health workers. Some lesbian women, for example, felt their needs should be met within women's health centres - that to accept a separate service for lesbian women would be to bow to the homophobic tendencies of the wider society. In Amsterdam, by contrast, a lesbian doctor found that her clientele largely comprised lesbian women, indicating a need for a lesbian centred service.

Women's health collectives have tried to emphasize the importance of the social model of health through their organization. If all aspects of a woman's life affect her health then, logically, all kinds of health workers including counsellors, nurses and doctors are of equal importance in bringing women to a state of wellness. As a consequence, shared duties, equal pay for all workers, and consensus decision-making have been features in the development of women's health centres.

However, in many cases, particularly in government funded centres, the collective emphasis is considerably diluted. Funding is often structured in terms of job function and community standards of remuneration. Thus doctors are paid more than clerical staff. The introduction of inequalities from outside make it difficult to sustain

an egalitarianism in which all jobs are considered of equal importance. In some centres funding is pooled and each paid member of the collective takes the same amount. A number of women's health organizations, for example Liverpool in Sydney, have experimented with sharing all jobs so that the receptionist and the health worker are all equally well informed. In many cases, though, individual staff members have withdrawn to separate, specialized functions.

PROFESSIONALS IN WOMEN'S HEALTH ORGANIZATIONS

A primary cause of the need for diversified roles within women's health centres stems from the need to employ accredited professionals - doctors and nurses. A complex relationship has developed between the new forms of organization in the women's health movement and such professionals.

The feminist critique of health services starts from the belief that "Health care reproduces the prior distribution of patriarchal power, through its structure of dominant male doctors and subordinate groups of women as patients or nurses." (Davis and George 1988:19) Moreover, the advent of a male dominated medical profession has been viewed as an intrusion on women's traditional roles:

women have always been healers. Until the nineteenth century, when professionalized medicine became the province of male doctors, wise women, trained by their mothers, aunts and grandmothers, were the doctors, midwives, nurses, therapists, and pharmacists." (Hasselbring and others 1987: xiii)

The thrust of the women's health movement has, in consequence, been one of self-care, self-help and deprofessionalization. However, in the western world, doctors have the established medical power, through licensing procedures, to decide who does what. It is, therefore, necessary to work with doctors in women's health centres. There have been some attempts to transfer skills to lay workers, but, on the few occasions when this was discussed during this study, the idea was treated with great caution. Part of the reasoning was that professional licensing brings with it accountability. Moreover, the transfer of medical skills to lay workers was seen as risking women's health by offering unqualified treatment. In general, the argument has evolved to being more of a demarcation dispute between doctors and nurses than a plea for a transfer of skills and power to lay workers.

Nurses have become more militant in seeking to have their high levels of training better acknowledged by the communities in which they work. They have sought greater autonomy through the role of nurse practitioner, and of midwife, both within hospitals and in the home-birth movement. However, some of these moves can be criticized as being little more than an exchange of power between professionals, which may do little for client empowerment.

Overall, a new role has been demanded of health professionals within women's health centres: "The role of professionals may need to be demystified or de-professionalized. This requires the professional to lay aside the status and authority he [sic] accepts and expects from his role." (de Meyere and Jezewski 1985:25) Most importantly, women's

health centres have provided a context in which health professionals can do their job properly.

Women's health centres allow doctors and nurses to work with a holistic view of health. Where doctors' skills fade, structures are in place to develop treatment in non-medical ways through, for example, consciousness-raising groups, fitness classes, workshops and counselling.

Counselling methods differ from those normally available to women and illustrate the changed relationship between client and professional:

The traditional counsellor/client relationship mimes many characteristics of the male/female roles. Prior to the humanistic psychology movement, most counsellors were male and most clients were female. Success in treatment reflects the degree to which a woman adjusted to her role of wife and mother. The counsellor labelled the client based upon how far she deviated from the norm. The norm for the healthy adjusted female once meant nurturing, passive and feminine.

The feminist counselling model considers both the client and the counsellor equal participants in the counselling process. It differs from other psychotherapeutic models in that its focus is on sex roles and female identity. The feminist counsellor relates to the client as a peer who has skills to share. One of these skills, which is valued highly, is the ability to articulate personal experience. (Miller 1986:1)

EFFICIENCY AND COLLECTIVITY

Efficiency was a big issue in the centres visited in this study. Consensus and collectivity may be empowering but they are also time consuming: "The empowering process takes much longer than more traditional methods; (consider, for example, the difference in time between hierarchical decision-making compared with consensus)." (Helean and Huygens 1986:199)

The concept of efficiency itself is often criticized as deriving from male, bureaucratic imagery, whereas women's health workers are often more concerned with effectiveness in directly meeting client's needs:

While our statistics show numbers of clients seen, the nature of their problems and the actual face to face contact time, they do not indicate the amount of time spent on follow-up tasks. These tasks include investigating referrals, gathering information, keeping records, case conferences with government agencies and the more exacting one of writing legal and medical reports, all necessary aspects of service provision. (Liverpool Women's Health Centre 1986:8)

This comment illustrates the difference between female and male modes of thinking: "One of the major beliefs of the male system is in the scientific method as the only valid indicator of success or failure, while the female system's primary belief is in the validity of process in and of itself." (McShane and Oliver 1978:621)

Nevertheless, this study revealed that many women's health workers were torn between the need to live by feminist principles (consensus and collectivity) while trying to deal with the many needs and issues in their local communities. Typical of the comments made were:

"My job is to provide resources for women in the community, not deal with the needs of the collective."

"I'm not going to consult every time I need to buy a syringe."

"I can't work with eight people as my boss."

The tension between process (how a group organizes) and product (what they achieve) was more acute in centres in the early stage of development, where a modus operandi was still being established. This was particularly so in cases where members of the collective changed frequently, thus necessitating the constant need to re-cover old ground. One nurse practitioner, caught in this situation, felt very strongly that she would be better off doing pap smears than spending time in lengthy meetings. Her comment raises the question of the appropriateness of collective organization in service delivery settings.

Whilst many would argue that collectivity does not imply structurelessness, the constant straining back towards something resembling a flattened management structure suggests that, in reality, organizational looseness is not universally appropriate in the women's health movement. Concerns of this nature were being voiced as early as 1970:

During the years in which the women's liberation movement has been taking shape, a great emphasis has been placed on what are called leaderless, structureless groups as the main if not sole organizational form of the movement. The source of this idea was a natural reaction against the overstructured society in which most of us found ourselves, the inevitable control this gave others over our lives...The idea of 'structurelessness' however, has moved from a healthy counter to these tendencies to becoming a goddess in its own right. (Freeman 1970:151)

Jo Freeman noted the importance of structurelessness at the consciousness-raising stage of development:

Its looseness and informality encouraged participation in discussion and the often supportive atmosphere elicited personal insight...The basic problems didn't appear until individual rap groups exhausted the

virtues of consciousness-raising and decided they wanted to do something more specific. At this point they usually floundered because most groups were unwilling to change their structure when they changed their task. (Freeman 1970:151)

Freeman took the analysis still further, pointing out that the goals of consensus and structurelessness may be unachievable, "a smoke screen for the strong or the lucky to establish unquestioned hegemony over others." (Freeman 1970:152) Her article is a healthy critique of the hidden agenda of some women's groups and could be used as the basis of an on-going critique in those centres in which collectivity has become a goddess.

Women's health centres not only face some of the organizational problems of conventional agencies but also additional problems stemming from the difficulty of sustaining ideologies (feminism, empowerment, a model of health) in a hostile environment. McShane and Oliver (1969:619-620) summarize the problems faced by alternative feminist centres as:

1. Forced modification of original goals and objectives;
2. lack of organizational structure and development;
3. reduced staff efficiency through constrained generalization; [i.e. no specialized functions];
4. inability to attract and hold top level employees;
5. heavy reliance on volunteer staff;
6. poor organizational relationships;
7. limited growth as an effective alternative to the conventional service sector; and
8. confrontation with the male system.

This study programme revealed that such issues are ongoing and that women's groups need to debate these issues at the local level in an effort to confront the rigidities not only of hierarchies but also of ideological certainty.

SPECIALIST OR SENSITIVE GENERIC SERVICES?

There is a danger that the creation of specialist health services for women will militate against the development of sensitive generic services. However, in Australia, the discussion paper on National Policy for Women's Health (1988:38) noted that women's health organizations challenge mainstream services as well as providing alternative health care facilities.

It may be that the flattened management structure, caring atmosphere and participatory decision-making processes which are everywhere evident in the women's health movement represent good role models for mainstream services. As the Youth Affairs Council of

Australia (1983:23) pointed out, the existence of alternative organizations "does not preclude existing forms of organization from commencing evolutionary processes towards these goals." Specialist and sensitive generic services are not, therefore, mutually exclusive.

The influence of the women's health movement is becoming more apparent in the organizational structures of mainstream health services. The Royal Women's Hospital in Melbourne launched a report in 1987 based on an extensive consultation with women in the local community. The Community Consultation Project was designed to make hospital planning more systematic and participative - in itself quite a step forward. The demands of the women are now bound to impel the hospital toward more empowering structures.

Another way in which women have attempted to change or at least cope with the organizational structure of hospitals is through advocacy. In London the "Multi-Ethnic Health Project, An Experiment in Health Advocacy" has been developed by the City and Hackney Community Health Council. Workers with the unit attend ante-natal clinics at the local hospital. The workers speak the various languages of the migrant groups in the district. They help with administrative tasks and accompany the women during consultations with doctors. They ensure that pregnant women are fully informed about the treatment offered to them. It is, obviously, a service which goes beyond simple translation.

With time, [the advocates] after observing so many doctors and midwives... have a measure of good and bad practice and the ability to speak up when care falls below acceptable standards, to remind staff that a woman should be offered a test, or ask to have a result rechecked because it doesn't fit with what a woman says. (Winkler 1985:4)

The extent to which the women's health movement should involve itself in mainstream services is a matter of some debate. Clearly, it is inappropriate to allow non-English speaking women to flounder in the health system and yet, at the same time, advocacy may be seen as a band-aid approach which contributes to perpetuating a medical model of care. Moreover, the inclusion of women's services in hospitals has not always resulted in satisfactory outcomes. Workers in hospital based sexual assault centres, for example, reported that such centres do not work well when they have to rely on resident doctors for crisis care. Far better is the model, developed in Western Australia, where sensitive, specially briefed doctors are on call.

FUNDING

Universally, the quality and level of health service to women is dictated by funding. Government funding normally comes with strings attached. Accountability for the spending of taxpayers money involves evaluative procedures, many of which are based on the medical model and standardized outcomes. Specifically, an efficient (high) turnover of patients militates against the qualitative and holistic assumptions of the social model of health. However, the absence of government funding means either that staff spend their time writing submissions for grants or that services are cut, as in Wellington, New Zealand, where the

women's health centre was, in 1988, open for only a few hours on one afternoon each week.

While there is a risk of co-optation in government funding, McShane and Oliver (1987:623) consider that it is still worthwhile to chase funds from conventional, mainstream sources because, "This money would then be channelled into a feminist service area and, even though the goals and objectives of the original organization may be modified, the funds are still being deflected from the conventional male sector."

Some centres visited were very concerned about government constraints, and sought funding from a variety of sources in order to preserve their autonomy and sustain their ideological goals. The Plymouth Women's Health Center, in America, is a good example of a collective which adopts this approach. The health workers obtained expert advice on fund raising and employed specialist staff to raise money for the centre. One strategy used showed a neat piece of feminist thinking: The "Pledge a Picket" campaign asked sponsors to pledge an amount of money for each "right-to-life" picket who plagued the centre's doorstep on abortion clinic days. Using this strategy the centre had an each-way bet: If the pickets did not come the centre was spared their tactics; if they came they helped to fund the centre.

So far the choice reported has been that between government funding - with its implications for co-optation - and alternative funding, which consumes the time of collective members that might otherwise be spent on health concerns. There are two alternatives, the first of which is to alter the government constraints. In 1988 the Brisbane Women's Health Collective received a grant to complete a 'Project of National Significance' on this very topic. They researched government evaluation models to establish procedures which might blend with the objectives of women's health centres. The second possibility is to place alternative funding on a more stable basis. In Boston 'Community Works' is a cooperative fundraising group. It accepts donations directly through payroll deduction and re-distributes this more stable source of revenue to member groups, all of which focus on those who face barriers in society due to race, sex, class, age and ability.

CONCLUSION

Most women's health centres focus on reproductive and gynaecological health. In so doing, they may unwittingly be facilitating a discourse about women which emphasizes that their difference from men is a problem rather than being normal. Valuable though separate services for women have proved to be, the risk, in the long run, may be that normal processes in women's lives will become even further medicalized and marginalized. However, the study showed that separatist women's health services can equally well serve, not only as excellent health centres, but also as innovative models for new forms of health care.

SECTION 4

SOCIAL ACTION AND THE WOMEN'S HEALTH MOVEMENT

SOCIAL ACTION AND THE WOMEN'S HEALTH MOVEMENT

NETWORKS AND SOCIAL ACTION

Networks are a key feature of the new organizational structures which have developed throughout the women's health movement. A number of state, national and international networks can be identified. To name but a few: the Latin American and Caribbean Women's Health Network; the Women's Global Network on Reproductive Rights; Women's Health Interaction in Canada; the International Council on Women's Health Issues and the National Women's Health Network in the U.S.A.. The goal of networking with like-minded groups is to share information, skills and strategies and to create an effective voice at policy making levels.

Social action, with a view to social change and policy development, is fundamental to the women's movement. Without a political dimension to their activity, women's health workers would be able to attempt only band-aid work on problems caused elsewhere in society. Networking has been the basis of such political activity: "Feminist organizations and groups have often affiliated into coalitions to strengthen and unify the smaller groups and to provide a broader base for social action." (McShane and Oliver 1978:615)

Sari Tudiver, of Manitoba, provides an excellent summary of networking in her article: "The Strength of Links: International Women's Health Networks in the Eighties" (1986 :187-214). In it she identifies some of the key issues:

Through newsletters and other means, women exchange information on a wide range of health issues; warn consumers about dangerous drugs and medical devices; lobby for better health legislation, and work towards developing good, alternative services, including preventive health education. It is through such initiatives that we seek to achieve greater understanding and control of our physical and mental health. (Tudiver 1986 :188)

THE INTERNATIONALISM OF WOMEN'S HEALTH ISSUES

Implicit in Sari Tudiver's comment is the international nature of women's health issues. First world problems quickly transfer to the third world. Battles won in the western world, for example, over the Dalkon Shield, Depo Provera and powdered baby foods, simply result in manufacturing companies marketing their wares in under-privileged countries, sometimes with deathly consequences.

Networks serve to disseminate knowledge quickly to pre-empt the diffusion of first world problems and to alert women to their rights on a world-wide basis:

A blatant example of a contraceptive device proved defective in design and dangerous to women is the Dalkon Shield. Marketed in approximately eighty countries, the device was officially removed from the market in the United States and Canada in 1974. In

early 1986,... women's health groups... were attempting to publicize widely the international recall of this intra-uterine device and the American court decision that set April 30, 1986, as the final date for filing liability suits against the manufacturer, A.H. Robins...

The April 30, 1986 date beyond which no woman anywhere in the world may sue the company allows it to limit its losses by denying women in Third World countries fair access to legal redress. (Tudiver 1986 :197)

The international nature of the Dalcon Shield issue is mirrored in action on DES (diethylstilbestrol). This drug was used in North American and Europe from World War II until the early 1970s, being prescribed to prevent miscarriage, although its efficacy was in doubt as early as the 1950s. Some daughters of the mothers involved are now presenting with a rare form of vaginal cancer. Two DES action groups, in USA and Holland, were visited in this study. What became apparent was the effectiveness of their networking:

They researched, compiled, and distributed essential medical information necessary for monitoring and treating DES victims. As a result, medical researchers are now monitoring DES-exposed daughters, sons and mothers and determining other health risks. (Tudiver 1986 :196)

THE INTERCONNECTEDNESS OF WOMEN'S HEALTH ISSUES

Tudiver's reference to other health risks is significant because, not only are women's health issues international in nature, they are also interconnected. DES Action, a group in San Francisco, is beginning to research the more general health issues which may be connected with DES, an example of their initial findings is presented in the following table.

Percentages of Asthma, Arthritis and Lupus Reported			
DES Exposed		National Health Information Survey	
		Asthma	
DES daughters	9.6%	NHIS women, 17-44 years	2.6%
DES sons	14.9%	NHIS men, 17-44 years	2.2%
		Arthritis	
DES daughters	7.8%	NHIS women, 17-44 years	5.8%
DES sons	8.5%	NHIS men, 17-44 years	3.7%
		Lupus	
DES daughters	0.7%	General population, all ages	0.002%
DES mothers	1.0%	General population, all ages	0.002%

(DES Action Voice #27:4)

DES Action in Holland has focussed on the central issues of what happened to DES mothers in the past and identified links to what is now being done to women in the area of reproductive technology:

In my opinion the DES problem is not an incident but is inherent to the way the health care system is structured, the position of the medical profession and the drug companies and the way in which women are used in experiments without knowing...The DES problem can be a warning for IVF [Invitro fertilization] developments...

1. Both DES and IVF are medical technologies which influence women's reproduction..
2. Both technologies are medical experiments on healthy women...
3. Both technologies, DES and IVF, did not have to be proven safe for women. The idea is that it is safe until it is proven otherwise. (Direcks, unpublished thesis).

INTERNATIONAL NETWORKS ON REPRODUCTIVE ISSUES

Acknowledging the international and interconnected nature of women's reproductive issues, the Women's Global Network on Reproductive Rights works to maintain contact with more than 400 groups and individuals in over 70 countries. From its headquarters in Amsterdam it publishes newsletters in Spanish and English and periodically facilitates conferences as well as conducting special promotions on particular issues. In 1989 the focus was on maternal mortality and morbidity.

Issues surrounding maternity provide another focus for international social action by women's health networks:

Alternative perinatal services form an international movement; despite the differences among nations (in health care systems, health care needs, stage of development of alternative services), there is a sense, among users and providers of alternative perinatal services in all countries, of participating in a world-wide movement with a core of common aims and strategies. (W.H.O. 1985:54)

Fertility issues, in general, illustrate the relationship between women's health and national policy issues, hence the need for national and international networks. While in some countries abortion is illegal, in China women are subject to compulsory abortions in late pregnancy. The legislative concern has been national population policy, not women's health. Sometimes religious values inform such policies. In Catholic Eire, for example, even condoms have been available only on prescription. However, religious values may quickly bend when the threat is to men as well as women. The advent of AIDS has resulted in the easier availability of condoms in Eire.

While, in the third world, international aid is often tied to fertility control programmes, in the first world millions of dollars are spent on reproductive technologies designed to enhance fertility. FEMRAGE is an international network working to promote awareness of the issues surrounding reproductive technology. These include: the low success rates; the iatrogenic causes of infertility; ethical issues; motherhood ideology; the medical profession's control of hormone treatment; and, finally, the experimental nature of the work.

SOCIAL ACTION AND SOCIAL POLICY

Networks provide information which can be used to influence social policy, thereby improving the context of women's lives. Social policy is "one of the means by which society translates its goals into practice." (Youth Affairs Council of Australia 1983:17) This being so, feminists have argued that existing social policy goals are blatantly sexist serving to maintain women in "relations of dependency within families...putting women into caring roles and...controlling the work of reproduction." (Pascall 1986:3)

Some feminists have therefore concluded "that all state interventions have the effect of maintaining the existing system of productive relations and existing class and gender inequalities." (Baldock and Cass 1983:xvi) However, the system by which society's goals are translated into practice is one of political negotiation and other feminists have identified welfare as an area in which women can win by achieving the redistribution of income to women:

In the Australian welfare system the winning of widow's pensions, supporting parent benefit, family allowance, child care centres and women's refuges, represent gains which redistribute explicitly to women and which extend the sphere of women's freedom. (Baldock and Cass 1983:xvi)

THE DEVELOPMENT OF SOCIAL POLICY

The development of social policy in the western world has traditionally been shaped by party political ideology, lobbied for by competing pressure groups and drafted by bureaucrats. This process is adversative resulting in a situation in which the powerful win. In contrast, the development of the National Policy on Women's Health, in Australia, is notable for its emphasis on consensus:

Taking into account the representative nature of many organisations ... as well as individual submissions, more than one million women in Australia contributed to the formulation of the National Women's Health Policy. (Commonwealth of Australia, 1989:3)

Policy may be developed at local, state, national and international levels. On the surface, local policy development appears to offer more opportunity for consultation. However, the Australian example shows that consensus can be achieved at the national level.

A national policy on women's health avoids the pitfall of regional inequalities within one country but, increasingly, the focus of the women's health movement has turned to international issues. In Europe, women are now using the European Parliament to set policy on issues such as D.E.S. Session document B2-1242/87, for example, calls upon the Parliament to:

- prohibit as quickly as possible use of DES for any type of illness;
- adopt measures with all due speed to prevent the production of DES and its export to the Third World.

A truly global perspective on policy as it pertains to women's health is adopted by the World Health Organisation. The 1981 Code on Breastmilk Substitutes is just one example of WHO policy in the arena of international health issues.

POLICY AND MODELS OF HEALTH

To the extent that the development of social policy is the outcome of political negotiation then in the field of health the contest has been won by "advocates of the medical model [who] enjoy special authority in modern societies." (Broom 1983:276) Russell and Schofield (1986:148) conclude that "Our system of 'health care' is perhaps better described as a system of illness management and control." The women's health movement has proffered the social model of health as an alternative direction for health policy.

There is, however, a contradiction inherent in using the social model of health as the basis for the development of specific health policy because this perspective requires a consideration of the total context of women's lives, not just their health. In Australia the National Policy on Women's Health has tackled this problem by pointing to the need for intersectoral co-ordination:

The health status of a community or group within a community, is linked to broader socio-economic issues of distribution of resources. For women, therefore, analyses of health policies to overcome health inequities should encompass the full range of socio-economic factors. These include gender inequities implicit in issues such as poverty, employment, access to educational opportunities, transport, housing, child care, sexist stereotyping in the media and so on. (National Policy on Women's Health: A Framework for Change 1988:2)

PHILOSOPHICAL BASIS OF WOMEN'S HEALTH POLICY

The philosophical basis of the development of women's health policy has varied from country to country. There are, "Those who stress the similarities between men and women...because they recognise that the concept of a distinctive 'female nature' has been used for generations to relegate women to second-class citizenship." (Broom 1983:262) Others argue that women deserve special consideration, positive discrimination, to compensate for past inequities. In any

case, in the health area, "Women's distinctive reproductive processes are potentially relevant to the entire range of their social experience." (Broom 1983:262) Australian women's health policy has walked both roads arguing for sensitive generic services as well as a parallel system of women-centred health services.

Clearly, Australia has worked towards specific women's health policies. At State level there have been a variety of reports: Report of the Working Party on a Women's Health Policy, Adelaide 1984; Women's Health in New South Wales, Sydney 1985; Women's Health and Well-Being, Perth 1986; and Why Women's Health? Victorian Women Respond, Melbourne, 1987. The culmination has been a National Policy on Women's Health, adopted by the Federal Government in 1989.

Australia is not unique in developing specific policy direction for women's health. In New Zealand the Women's Health Committee Report (1985-88:7) called for the establishment of broad policy directions which cover "the totality of women's experiences rather than focussing primarily on maternity services, reproductive health and child-bearing areas traditionally labelled women's health."

The common aim in all of the reports is to develop "environments and systems...designed to become more empowering of individuals." (Hopson and Scally 1982:78) There are marked similarities in their recommendations: increased participation in decision-making for women; more funds for resources and research in the area of women's health; and the development of health promotion and preventative screening programmes. Special groups of women are acknowledged to have particular needs: Maori, Aboriginal, migrant, rural, young and aged women.

In Eire, too, there have been recent reports exploring the relationship between health and policy: Promoting Health Through Public Policy (1987), and Women and Health, Some Current Issues (Cullen and Morrissey n.d. xiii) which noted that

women's health status cannot be satisfactorily considered in isolated compartments, but requires consideration of the overall life situation of a woman herself and an understanding of the status and treatment of women as a group within society. Action to improve women's health thus raises social and political issues.

SOCIAL CONTEXT OF WOMEN'S HEALTH POLICY

Eire has not developed a fully fledged women's health policy, nor have Denmark and Norway. Scandinavian countries, traditionally, have better health and welfare systems than other western societies. Moreover, the basis of their policy development has been more supportive of women in paid employment.

Scandinavian social policies have not marginalized women into a reproductive role and perhaps, in consequence, women have not felt the need for the creation of separate women's health policies and services. Even in Australia, which has, perhaps, done most work in developing distinct policies on women's health, there is some feeling that a

special emphasis on women is a transitory phase of policy formation. In South Australia, for example, the women's health unit eventually devolved into a more general social health unit featuring the special health needs of a variety of groups - women, Aborigines and migrants.

POLICY IMPLEMENTATION

The success of any social policy depends on the process of implementation - organizationally and in terms of funding. In Western Australia it was recommended that a Women's Policy Unit be established within the Health Department and that the Director of the Women's Health Policy Unit report directly to the Commissioner of Health. As in South Australia, though, a limited time frame was foreshadowed: "It is recommended that the establishment of the Women's Policy Unit be for a time limited period with a review after either three or five years." (Women's Health and Well-Being 1986:vii) Health administration within each State in Australia has traditionally been highly centralized. In this context a women's health policy unit can work successfully at the bureaucratic centre to influence the course of events. However, there are those who see in this a process of co-optation which does little to alter existing power structures or make needed changes. What is less certain is how women's policy units can be effective in the decentralized systems which are now emerging in Australia.

It seems hard to credit that the bureaucracies which have been seen to oppress women can also offer protection for feminist goals and objectives. In New South Wales, in Australia, there was concern that decentralization would not only dilute the issues but remove control from women to regional hospital boards. Superficially attractive community control became questionable in the light of the potentially conservative (anti-abortion) community beliefs which might dominate regional boards. The processes by which people are nominated to decentralized boards and the few women represented on those boards were issues which led some women's health workers in New South Wales to favour centralized administration. Jane Lewis (Mitchell and Oakley 1986:83) lends weight to their suspicions: "There is no returning to an old or newly romanticized 'community control' when the remnants of community rest on a power structure hostile to women's aspirations."

POLICY EVALUATION

Evaluation is an important feature of social policy, particularly insofar as it indicates a determination to show that words will be translated into action. In Australia the National Policy on Women's Health will be evaluated across sectors:

Effective co-ordination and the co-operation of all sectors will be needed to effectively implement the National Women's Health Policy. It is proposed that review, monitoring and reporting functions be undertaken through a Commonwealth and State-Territory structure. (Commonwealth of Australia 1989:15)

It is difficult to assess the importance or effectiveness of social policy in any general way. In Australia, women's health policies may simply be the icing on the cake - the final formulation of what has been happening anyway at grassroots level. Even worse policy can be

the icing with no cake - a barrier of words hiding a lack of action. By contrast, policy may enshrine the ideological goals of the women's health movement, setting clear parameters and objectives for all health services.

CONCLUSION

The extent and nature of women's health policy is shaped by the socio-political context of each country. The development of separatist women's health services in some countries is queried by women in other nations which have a longer tradition of legislation supporting women in both their work and family roles. Some women's health issues extend beyond national boundaries and in this context the World Health Organisation has a vital role to play, particularly in controlling the spread of first world problems to economically disadvantaged countries.

SECTION 5

THE SELF-HELP MOVEMENT

THE SELF-HELP MOVEMENT

THE RELATIONSHIP BETWEEN THE WOMEN'S HEALTH MOVEMENT AND SELF-HELP

Many women's health centres have evolved from self-help organizations and continue to be informed by self-help philosophies. The development of the self-help movement over the last twenty years has been astounding: "An exhaustive catalogue of these proliferating groups in the broad health and welfare field cannot yet be attempted because they are growing so rapidly and are in such a process of change as to outstrip the tempo of data collection." (Katz 1981:131)

The reason why self-help became particularly important in the women's health movement was:

The conviction that the state has never addressed women's needs in anything but an instrumentalist fashion - defining the needs of mothers, for example, in relation to a precise and prescriptive concept of motherhood as a social function - allows some feminists to be largely dismissive of state welfare and to turn instead to the self-help alternative. Such an alternative has obvious limitations in terms both of the policy field it can be applied to - health has probably been the most important - and of the number of people it can reach. (Lewis in Mitchell and Oakley 1986:85)

A case study of the process through which a self-help group evolved into an established women's health centre may be taken from Sydney, Australia. The starting point was International Women's Day, 1973. A speak-out was organized during which the need for more and better health information emerged as a paramount issue. Feminist activists took the initiative and developed a booklet: What Every Woman Should Know, which focussed particularly on contraceptive information for young women. The booklet was distributed to high school students, an action which produced a storm of community protest. Young women, it seemed, should not be exposed to such material. Instead, concerned women began offering health information from Women's Liberation House, keeping "hot and cold" lists of doctors and acting as a referral service.

While it was known that some doctors were prepared to terminate pregnancies, prices were high, and working class women were debarred from their right to choose. The referral service talked with doctors and offered referrals if prices were dropped. From this bargain-basement beginning, feminist activists were able to link into developing ideas of community health care and made a successful bid for funding during the Whitlam, Labor Government years. As a result the Leichardt Women's Health Centre was opened in 1974. Within nine months, four to five thousand women had used the centre - the need was demonstrated. From these self-help initiatives has grown a network of women's health centres in New South Wales.

Katz (1981:141) typified the transition from self-help to formal organization as a "natural history of self-help groups comprising five successive stages: Origin, Informal Organization, Emergence of

Leadership, Formal Organization and Professionalization." However, to the extent that self-help elements are still present, even at the formal organization stage, the model does not precisely fit the women's health movement. Katz acknowledged that the women's movement, in general, has avoided the stages of leadership emergence and formal organization.

SELF-HELP ORGANIZATION

In sharing a common history and continuing relationship, women's health centres and self-help groups also share the organizational tasks of instituting empowering structures and processes in a bureaucratic world.

Self-help groups are the antithesis of bureaucratic hierarchies:

Self-help...operates informally on a feeling of trust, friendship and equality. There is no distinction between giver and receiver, those helping and those being helped...at the heart of self-help is the belief that, given resources, information, skills and support, everybody has the right and capability to manage their own lives in ways which best suit them. (Jezewski 1986:5)

The ability of self-help groups to sustain informal and egalitarian structures depends partly on their stage of development. Where they remain at the level of mutual support, empowering processes are less difficult to maintain than in groups involved in direct service delivery. In other words, action groups may organize differently to support groups which "may need to concentrate most of [their] energies on mutual support and caring." (de Meyere and Jezewski 1985:17)

SELF-HELP OBJECTIVES

There is a need to clarify the objectives of self-help groups in the women's health movement since the goals of a group determine its organization and relationship to the wider society. Uljar and Hendron (1990:8) fear that:

The recent popularisation of self-help groups in the climate of 1980s conservatism, presents some dangers for self-help groups. In particular, self-help concepts are in danger of being misrepresented, re-defined, co-opted and depoliticised. There is a growing tendency to see self-help groups purely in terms of their mutual support function.

Uljar and Hendron (1990:8) see a clear political objective in the self-help movement and warn that, "The application of self-help terminology to groups which are supportive of, and supported by, existing repressive institutions undermines the concept of self-help."

SELF-HELP AND FUNDING

As in women's health centres, funding considerations influence self-help organizations:

Not all groups operate along the lines of pure self-help i.e. choosing a loose-knit informal structure. Some may adopt the less flexible committee structure because they see it as being more effective or may be forced to it by outside expectations. These might include the requirements of funding bodies which look more kindly on the traditional service model and expect a rapid turnover of people "serviced" or "cured"...The paradox here is, that while groups operate with little or no funds, the number of people benefiting must remain, of necessity, at the minimum. (de Meyere and Jezewski 1985:18)

SELF-HELP AND PROFESSIONALS

The relationship between self-help groups and professionals can vary from antagonism to mutual respect and support. Professionals can feel threatened by the basic philosophy of self-help because: "It is more than delivering a service - it is about supporting people and sharing skills and resources so they can create their own services and meet their own needs." (Jezewski 1986:5) Innocuous though this may seem, it is a philosophy which can threaten those who have become

self-protective, their priority being to maintain their privileged position, so ensuring their own continuity by making people dependent on them. This is the movement attacked so strongly by Illich in his book on The Disabling Professions (Illich et al., 1987), and by Dore in his analysis of The Diploma Disease (1976). (Hopson & Scally 1982:52)

Professionals are used to working in formal organizations. The more personalized relationship of self-help represents a challenge to their accustomed ways of behaving. Similarly, self-help groups may be wary of the intrusion of professionals: "While some professionals see their involvement on a consultancy basis...others may, quite unconsciously, lead the group to where they think it wants to go." (de Meyere and Jezewski 1985:25) During this study one self-helper commented that the local medical consultant, with whom they worked, referred to them as "my group". Not surprisingly this group has adopted a very medical approach to the issue of menopause - strongly supporting Hormone Replacement Therapy - a treatment which is regarded with some caution within the women's health movement generally.

Established self-help groups run the risk of becoming professionalized. During this study incidents were noted when self-helpers had fallen into a caretaking, counselling mode which did little to empower the person making an enquiry. The danger with untrained persons adopting a professional stance is that they run the risk of being even more disabling than trained professionals. On one occasion I witnessed a person at the pre-diagnosis stage of a life-

threatening disease being ground down by the weight of gloom and doom stories heaped on her by the self-helper whom she had approached for information. Not an isolated incident, it would seem, since one women's health worker in Canada referred to the fact that "mutual depression groups" are not always as empowering as they might be.

The conclusion of this critique is not that there is a demarcation dispute between self-helpers and professionals: "Self-help groups and professional services have different things to offer. There is a need for both and they can learn from each other." (de Meyere and Jezewski 1985:25) Rather, both professional and self-help strategies are worthy of ongoing critique to sustain their empowering impulses. A case study of just how hard this process can be may be found in The Family Centre Book, The Joys and Pain of Self Help in the Community, (Mills and Goldsmith 1984).

SELF-HELP AND EMPOWERMENT

There are possible dangers in single issue, self-help groups, particularly if the main focus is mutual support. The problem lies in the potential for solutions which ignore the social context. However, much of the literature emphasizes the political nature of self-help:

'Self-help', 'participation' and 'community development' are the processes of community politics. These processes 'empower' people so that decisions can be made from the bottom-up rather than being imposed from above. Self-help assists people to gain a measure of control over their own destiny...This control emphasizes, rather than negates, the responsibility of government in providing financial and other resources to assist in this process of self-help. One of the ideal objectives of community politics and therefore of self-help...is the equitable distribution of power over the whole community. (Community Quarterly, No.13, 1988. Back Cover)

In Western Australia the self-help movement has organised in a manner which may avoid the problems emerging from single issue groups. The Western Institute of Self Help (W.I.S.H.) has sponsored and encouraged the development of a network of self-help groups:

[W.I.S.H.] is composed of self-help groups who [sic] have come together to support each other and increase community awareness of self-help. It is a link in the self-help movement responding to the needs of self-help groups. (Jezewski 1986:3)

CONCLUSION

There are many parallels between the issues faced by self-help groups and women's health organizations. The fact that the women's health movement has, to a large extent, emerged from self-help beginnings explains many of the similarities. However, the parallels may also be accounted for through the influence of similar ideological roots.

SECTION 6

WOMEN'S HEALTH PROMOTION

WOMEN'S HEALTH PROMOTION

IDEOLOGY AND WOMEN'S HEALTH PROMOTION

The social model of health stresses prevention and health promotion: "A significant change in general health policy during the last decade has been the revival of the venerable tradition of prevention (rather than cure) and its extension to the concept of 'health promotion'." (Broom 1983:268) Prevention incorporates public health measures and screening, while health promotion empowers women with information about their own bodies.

The social model of health clearly directs attention to the social context in which wellness and ill-health are produced. This is important because it became apparent, during this study, that empowerment in the area of women's health promotion was, at times, being misinterpreted - the focus was too much on individual health concerns. This has been called "healthism":

Keeping healthy can also become a moral issue. Individuals are made to feel guilty for getting sick. People shake their heads disapprovingly over those who 'don't take care of themselves'. In many cases this amounts to blaming the victim; it shows a failure to recognise the social and economic influences on health habits and illness. (Boston Women's Health Book Collective 1971:3).

The misapplication of empowerment philosophy arises partly from the fact that it is easier to deal with the problems of an individual woman than it is to change the world: "The sheer enormity of the idea of removing the inequality...is enough to give anyone pause." (Fletcher 1988:6) However, Fletcher (1988:6) goes on to point out that change, at this level, does not necessarily mean "storming parliament and seizing all private property." Instead, it can mean putting a woman, who is, for example, a victim of criminal assault within the home, in touch with a women's refuge: "This would be a start to giving a voice to people in the oppressed group." (Fletcher 1988:7)

Self-help has become an important component in women's health promotion, and may be empowering insofar as it leans to lay autonomy. The Medical Self-Care magazine and the Book of Women's Health (Hasselbring and other 1987) are typical of this approach. However, "self care can be practised by individuals alone, or in an intimate setting such as the family, [and] does not require participation in a more formally or purposefully organized group." (Katz 1981:137) In other words, by teaching self-care skills, such as assertiveness, improved self-esteem and relaxation strategies, health workers may be divorcing personal solutions from the social causes of women's condition:

What health services teach as coping strategies (communication skills, stress management etc.) are adaptive mechanisms which do not enable people to tackle the cause of the problem but rather reinforce

the idea that we are powerless to change aspects of our environment. True empowerment skills will be highly specialized to each group and its problems, and must be devised by the group so that they fall within the group's capabilities and experience. (Helean and Huygens 1986:194)

Nevertheless, personal responsibility for health care is an attractive component of the women's health movement. Empowerment through knowledge and skills, such as new dietary and exercise patterns, is praiseworthy - part of taking control of one's life. However, the cautionary tale is that an over-emphasis on the individual dimension of personal responsibility can be used by funding agencies to avoid the provision of needed services. For example, the woman using tranquillizers may benefit from the personal insight that : "Addiction is a power game - a game of submission, control and enslavement - which is closely correlated with low levels of self-esteem and self acceptance." (Moss 1982:6) However, the same woman needs more than assertiveness training to improve self-esteem. She needs good housing, a reliable income, child care and equal opportunity with others in her society. It is particularly important to stress this point because the "pressure on women to be healthy is great, we carry responsibility, not only for our own well-being, but also that of our families." (Women's Health Resource Collective 1985:36) The gender trap is clear: "whilst women are held responsible for their own and their family's health, society is saved from any responsibility." (Women's Health Resource Collective 1985:36)

THE SOCIAL AND POLITICAL CONTEXT OF HEALTH PROMOTION

The social and political context of health promotion is important because it continues to manufacture ill-health (through pollution, high pesticide use, repetitive and dangerous work) at the same time as health promotion messages are being given to individuals. Moreover, the context of health promotion can be directly counterproductive of the message. Broom (1983:269) points out that there is an irony in promoting the health benefits of breast feeding when "social policies developed for other purposes have the unintended consequence of making breast-feeding more difficult." Diminished rights to maternity leave and limited child care facilities at the workplace, for example, discourage breast feeding.

THE HOME-BIRTH MOVEMENT IN HOLLAND

A case study of the home birth movement illustrates the importance of the social context of health promotion. The women's health movement has encouraged efforts to de-medicalize childbirth. Promotional activities have included booklets and pamphlets, for example: Every Women's Guide to Tests During Pregnancy and Obstetric Tests and Technology, A Consumer's Guide. Social action to initiate birthing centres, independent midwifery services and refunds on the costs of home birth, have been partially successful. In Australia, for example: "The Minister for Health...is examining ways of covering the cost, but has ruled out extending Medicare to pay for midwife services." (The West Australian 15 June 89:12) With regard to homebirth, Holland is the most successful country in the western world,

sustaining a rate of 34% of births at home. The reason for the Dutch success lies in the social and political context.

In Holland there is a well-developed system of midwifery practice. The midwives are trained at Midwifery Colleges because:

there has to be a difference between the education of a hospital nurse and a midwife...who is happier if she has been able to avoid an artificial delivery than to assist it and who sees herself more as an assistant to nature than an assistant to the doctor. (Kloosterman N.D.:11)

Documentation from the 'Kweekschool Voor Vroedvrouwen' in Amsterdam indicates that upon completion of training the midwife is considered by law to be a member of the medical - not the nursing-profession.

Selection of pregnant women is part of the basic philosophy of obstetric care in Holland. Selection is designed to concentrate high risk clients into well equipped hospitals leaving the majority of low risk women to choose home delivery with an independent midwifery practice. Screening is based on a medical indications list which is worked out in consultation with doctors, midwives, insurance companies and government departments. Insurance companies have considerable influence. They noted, for example, that hospital confinements were increasing and asked for a list of medical indications so that the higher cost of hospital confinement might be justified:

If there is a medical indication for the hospital confinement, the costs are paid by the Health Service (compulsory insurance) or by private insurance. If there is no indication for a hospital confinement, the Health Service pays the fee of the midwife and the major part of the costs of the maternity home help. The system in the Netherlands tries to avoid financial pressure in the choice between hospital and home confinement for healthy women. (van Alten 1984:4)

A new mother may request a live-in maternity aid nurse for more than a week after the birth of her baby. This post-natal service is considered a cornerstone of successful home birth. "To my knowledge no other country in the world provides a similar system of home nursing care." (van Londen 1987:4)

The success of the Dutch home birth movement derives partly from "a long tradition of home care, and delivery at home." (van Louden 1987:2) That tradition is now supported by senior Dutch obstetricians, government, insurance companies and specialist midwifery training. It is this social context which has resulted in an attitude which regards birth as a natural process. The context supports the health promotion message.

By contrast, in Eire, social structures work against the message that women have a fundamental right to make choices about their bodies and their lives. In Dublin, the women's health collective is under

legal injunction not to give information about abortion. Moreover, it is not allowed to offer advice on where to get information.

SOCIAL ACTION SKILLS

If the promotion of women's health is bounded by the context of the message then the logical outcome is that women require skills to improve the context of their lives.

The Women's Advisory Council of Western Australia has concerned itself with the need to develop social action skills. Its book, The Sky is the Limit, teaches the art of lobbying. The format is particularly noteworthy because it avoids a didactic approach. Other publications, too, focus on issues which move beyond personal health skills, for example, If You Have a Complaint About the Health Service, a brochure produced in Melbourne. Similarly, the Ministry of Women's Affairs in New Zealand has produced, Every Women's Guide to the System, Government Policy and You, and in Canada the Canadian Advisory Council on the Status of Women has developed, Play from Strength, A Canadian Woman's Guide to Initiating Political Action.

THE BACKGROUND OF WOMEN'S HEALTH PROMOTION

In the spring of 1969 the "doctor's group", as it was first called, began meeting in Boston, U.S.A. It is now known as the Boston Women's Health Book Collective. The members produced the book Our Bodies : Ourselves, which was revolutionary, not only in its intent to empower women with knowledge, but in the manner in which women's own experiences were incorporated as a central concern - "over time the facts and feelings melted together in ways that touched us very deeply." (Boston Women's Health Book Collective 1971:1) The production of the book highlights a number of features in the creation of women's health information: The women worked collectively; fact and feeling were mingled; lay women showed that they could handle technical/medical information and relay the knowledge in understandable language; and, finally, the book included an acceptance of self-help and alternative therapies. Sister publications have emerged which reflect the life experiences of the collective: Our Children: Ourselves, and Ourselves Growing Older.

WOMEN'S EXPERIENCE AND HEALTH PROMOTION

The Boston Women's Health Book Collective highlights one of feminism's major heuristic contributions - the importance of experience. The sharing of experience has become an important part of women's health promotion. This theme was used by the Women's Health Resource Collective, in Melbourne, in its publication Side Effects, Shared Experiences of Women's Health Care.

Shared experiences make apparent the universal nature of women's concerns as illustrated in the following comments from different women (Women's Health Resource Collective 1985:47):

You try not to be a burden, that's my biggest worry in life, that I'll be a burden on my family...as long as I can keep my independence I'll be happy.

I'm frightened of the future. I'm frightened of dependence. Most people don't want to be bothered by anyone who's dependent on them.

Sharing experiences is, then, a process which connects the personal to the political and focuses attention on the source of the problem as much as its solution. It is also a process which is simply an exchange of information among women. In their book, Giving Birth (1987), Dutch midwives Saskia van Rees, Beatrijs Smulders and Astrid Limburg, with obstetrician, Professor Kloosterman, built on the personal views of women who have given birth at home. As well as exploring options for childbirth they also documented detailed interviews which offer reactions and feelings thereby highlighting the personal choices of women. Beautiful photography in the Dutch version of the book (accompanied by English translation) relates, intimately, the meaning of childbirth.

THE FORMAT OF WOMEN'S HEALTH INFORMATION

Over the last twenty years women's health information has burgeoned. It has been produced in print, audio and video cassette and film. Information has been tailored to suit the needs of different groups of women and generally includes a perspective which encourages women to question and to take charge of what happens to them in terms of health.

PRINTED MEDIA

This study revealed that high gloss productions were eschewed by some women's health workers as expensive, slick and off-putting. Other groups saw high quality presentation as representing a professionalism of which women are deserving. The first group's view generally prevails because most literature is produced on a shoe-string budget.

The format and length of written material was noted as an issue during the study. The range is from three-fold brochures to full scale books. Somewhere in the middle the Montreal Health Press has produced books of about 50 pages which aim at depth without being overwhelming. So far they have published on: birth control; menopause; sexual assault; and sexually transmitted diseases.

Other groups have chosen the more flexible system of folders or envelopes of material collated on a particularly topic. In Winnipeg, the Women's Health Clinic has produced a range of envelopes on: menopause; women and AIDS; P.M.S.; diet and body image; and pregnancy. The Vancouver Women's Health Collective has a variety of excellent folders, called Self-Help Workshops, which are particularly effective in raising issues such as 'medical conditioning' and tackling topics like D.E.S. with titles such as The Wonder Drug We Should Wonder About.

Style is important, especially when catering for special interest groups. The Committee on Unplanned Pregnancy, in Winnipeg, produced comic-style booklets on birth control for young people. The Big Break Comics contain informative stories, values clarification exercises and quiz pages, all of which seek to improve knowledge about conception and contraception. In a similar vein, women's health workers at Sydney's Royal Hospital for Women, have produce a board game

called Sex: The Game, which aims to introduce young women to information about sexuality and sexual health in a non-threatening manner.

The imperatives of multicultural society have resulted in a range of multilingual health material. For example, the Immigrant Women's Health Centre, in Toronto, has produced the Immigrant Women's Health Handbook, A Book by and For Immigrant Women, which includes sections on the female and male reproductive systems, contraception, abortion, vaginal infections, sexually transmitted disease, cancer prevention and wellness. The book is produced in a variety of languages including Chinese, Spanish, Italian, Vietnamese and Portuguese. The information is detailed and explicit, reflecting the straightforward and matter-of-fact style of women's health literature produced by feminists.

Printed media, in any language, assumes literacy. Indeed, much of the women's health promotion material is written at quite advanced reading levels. In order to improve access to information for women with more limited reading skills the Vancouver Women's Health Collective is developing a series of health promotion books, written at a lower reading level.

AUDIO-VISUAL MEDIA

Where illiteracy is a problem, audio-visual media can be useful. Film, video and audio-cassettes have been widely used in women's health promotion, as feature length productions or in promotions which adopt advertising techniques. The Winnipeg Committee on Unplanned Pregnancy used a radio and television advertising campaign called "Respect Yourself, Protect Yourself" to raise consciousness about conception and contraception as part of a life-long decision-making process. The media campaign was accompanied by advertising in public transport vehicles and the previously mentioned Big Break comics. The Western Australian Government sponsored a "Quit Smoking" and "Drink Safe" advertising promotions have sought to alert women to the health hazards of alcohol and tobacco. Similar strategies have been used in New South Wales and Western Australia to raise awareness of the issues underlying tranquillizer abuse.

While consciousness of the issues is an important first step, the point is to improve women's knowledge about their own bodies. The National Film Board of Canada (N.F.C.) and the Body Language Foundation in Holland are developing films which raise awareness and knowledge about issues pertaining to women's health.

All city branches of the N.F.C. have developed excellent films about women's health but Studio D of the Montreal branch deserves particular mention. Studio D is run by and for women. Its stated aim is to make films from a feminist perspective. Response to its work has been very positive but there are dissenters. Rich (1987:346) identifies, as typical of N.F.C. productions, films which are, "concerned, engaged, up to the minute on social questions, but slick, manipulative, avoiding all the hard questions to capture the ready success of answering the easy one." It may be that the role of audio-visual media is to raise awareness rather than to pursue issues in

depth. Rich's judgement seems harsh in the face of the range of interesting material being produced by the NFC.

Highlights of the N.F.C.'s work include: DES, An Uncertain Legacy; Feeling Yes, Feeling No, aimed at empowering children to say no to unwanted sexual advances; Is it Hot in Here?, about menopause; P.M.S.; Not a Love Story, about pornography; and To a Safer Place, a very moving video about incest. A comprehensive list of N.F.C. productions, from all studios, is provided in the catalogues, Beyond the Image, A Guide to Films about Women and Change (1984) and Our Bodies, Our Minds, Film, Video and Multi-Media Resources for Health Education (1984).

The Body Language Foundation in the Netherlands has also been active in producing videotapes on issues relevant to women's health, in particular home birth. Titles include: With Both Feet on the Ground; Look...A Baby/the First Hour; Born Too Soon; and Flexible Maternity Care.

THE HIDDEN AGENDA OF CONTENT

While audio-visual media can be usefully incorporated into health promotion campaigns for women, it is important to note that the hidden agenda of the media and print message can structure discourse in ways which are counterproductive to the status and health of women.

An article in the New Zealand feminist magazine, Broadsheet illustrated this point with reference to the media's handling of sexual abuse:

Incorrect statistics used in the telethon advertising seem to have sparked off a hunting season in which feminists and workers in the field of sexual abuse are fair game. But by focussing on statistics and throwing up a smokescreen of anti-feminism, the media has diverted the public's attention from the real issues and failed to ask vital questions. Why are children sexually abused, and what is it about our society that produces and allows sexual abuse to keep happening? (Sabbage 1989:29)

The "hidden agenda" refers to implied meaning. This can be derived from the context in which a message is offered or from the manner of offering. The implied meaning may be louder than the message, as in the classic example of the lecturer who took two hours to explain that attention spans last only about 40 minutes.

Typical of how it is possible to get things wrong is a brochure on P.M.S. produced, in Australia, by a doctors' organisation. While the intention of empowering women with knowledge was good, the very ordering of that knowledge within the brochure reflected a highly medicalized perspective. The presentation of the three-fold brochure, with the front page wholly devoted to the crest of the group surrounded by a regal, purple edging, suggested an authoritative source of information. The crest included pictures of Australian fauna leaving at least one Australian woman somewhat bemused about the connection between P.M.S. and a platypus.

It is, of course, impracticable to get it right for everyone all the time - what some have called falling into the "one legged black woman" syndrome. However, white, heterosexual, middle-class assumptions of normality have, in the past, meant that, lesbians, disabled women and women of colour have not had their views properly represented. In this context the sin is one of omission. The "hidden agenda" refers to content (rather than presentation) and includes what is not said as much as what is said. If, for example, the message is always focussed on personal health skills then the implication is that social action is less important, even unimportant.

This study programme revealed that there is some concern about a hidden agenda of heterosexist assumptions in women's health literature. Consequently, lesbian women have started to write their own literature. The Centre de Santé des Femmes de Montreal, for example, has published Bilan de La Clinique pour lesbiennes and a brochure, Sante-Vous lesbiennes. In New Zealand the Palmerston North Women's Collective has produced a document entitled Fighting Homophobia and Heterosexism while, in Auckland, the Lesbian Support Group has developed a three-fold brochure, Lesbians and Will Making. The Vancouver Gay and Lesbian Community Centre Society is actively working to promote its concerns as part of public debate and the Vancouver Lesbian Center has also run a Lesbian "Outreach Project". In London the Women's Health Information Centre has written Getting Pregnant Our Own Way, A Guide to Alternative Insemination, and, finally, in Utrecht the Vrouwengezondheidscentrum has published a brochure on lesbians and AIDS entitled, Lesbisches Vrouwen en AIDS.

The concept of the hidden agenda has not escaped the attention of those who would criticize the production of women's health information. In the United Kingdom the publication of material on homosexuality has been blamed for actually promoting homosexuality. New legislation in England now limits public discussion of homosexuality for this reason.

Hidden agenda also refers to the content of what is said. The National Film Board of Canada productions have, in this context, received some criticism: While many applaud the video Feeling Yes, Feeling No, because it empowers children to say no to sexual advances, others feel that it is inappropriately oriented and lays responsibility at the door of children when it would be better directed at men. The film, Not a Love Story has also been criticized for backfiring in intent. B. Ruby Rich (1987:340-354) called it a "moral tale", a "latter day parable", which fails to question male-female power relations. The judgement is that "the anti-porn film is an acceptable replacement for porn itself, a kind of snuff movie for an anti-snuff crowd." (Rich 1987:343) The film is about women being exploited through the pornographic industry. Any critique of the audience is implicit rather than stated:

Male customers are...protected in their anonymity...
This is a serious mistake, but it's a clue to the
film's attitude. At no point does the camera offer a
shot from the point of view of the women on the stage.
We're never permitted to share their experience while
they're working - to inhabit their perspective when
they're supposedly being most exploited and

objectified. The result is a backfire: we remain voyeurs, and they remain objects - whether of our pity, lust, respect or shock makes little difference. (Rich 1987:345)

By contrast, a good example of getting it right is the National Film Board of Canada production P.M.S., which exposes the full range of women's experience and avoids a discourse which suggests that normal life experiences for women are abnormal and requiring of a medicalized response.

THE COLLATION OF WOMEN'S HEALTH INFORMATION

The array of women's health print and media resources has been collated in a number of ways - first of all in resource books such as Minority Women, Health and Healing in the U.S.: Selected Bibliography and Resources (Ruzek and others: 1986); and Teaching Materials on Women, Health and Healing (Clarke and others: 1986). Secondly, there has been a development of data bases such as the H.E.A.P.S. project (Health Education and Promotion System) in Australia. H.E.A.P.S. is not geared to women's health needs in particular, recognizing that it is important that women's health material be merged with more general resource collections. The Brisbane Women's Health Centre is working on a more specific manual of women's health promotion in Australia. It is planned in loose-leaf form to facilitate up-dating and contains an historical and theoretical section which explores the principles, context and practice of women's health promotion. As well as a resources section, there will be case studies to illustrate the centre's model of women's health promotion.

THE DISTRIBUTION OF WOMEN'S HEALTH INFORMATION

Many cities have women's health information centres. Typical is the Women's Health Resource Collective in Melbourne which has a good resource collection, some of which was produced by the members. Most information centres offer a telephone information and referral service and act as drop-in centres. Many initiate community projects and education programmes. Almost invariably they participate in social action to promote women's health.

Poor funding often inhibits the work of distributing information but, in Melbourne, there is now a government funded "Healthsharing" centre located in the heart of the city. Well appointed though it is, it cannot reach all women. Particularly disadvantaged are non-English speaking women in paid employment. Telephones are difficult for them to use, and work and domestic commitments mean that these women have little time for city centre visits.

In Sydney the Women's Health in Industry group has done an excellent job in getting health information out to employed migrant women. Group members collate material, prepared by the State Health Department and by women's groups, into language packages. They then travel out to small workshops and factories and obtain the owner's permission to talk with female employees during their lunch hour. They visit twice. The first visit is introductory and relevant language packages are distributed to the employees. During the second visit members respond to questions arising from the previously distributed

material and show the women's health promotion video Down There in the appropriate language or offer a simultaneous translation.

Group members have been careful to distinguish between occupational health and using the workplace as a health forum. They feared that access to the workplace might be inhibited if employers saw the group promoting occupational health issues. Furthermore, clothing manufacturers in Sydney employ a lot of out-workers who cannot be reached through factory based health forums. The Women's Health in Industry group once held community workshops for out-workers but funding cuts have forced their cancellation.

The Women's Health in Industry Group comprises women who are themselves migrant. Thus the range of languages in which they can distribute information is extensive. What they have done is to target the lunch break, the brief half-hour in a day when migrant women might have time to think of themselves. They reach women who might not otherwise have access to information about personal health issues. In spite of this, some criticism of their endeavours has been made by other women's health workers. They claim, firstly, that the project is invasive and imposing, and, secondly, that the programme lacks professional pre-testing and follow-up evaluation.

These criticisms are mentioned because they raise issues which should be confronted. In particular: Is it better to do something, even in haste, which reaches a lot of women or to work in a planned way which may cost more and reach fewer women? There is a danger of misinformation in hastily given health promotion, but the fact that isolated women are being reached does, on the surface, seem highly commendable.

In Canada a more profound criticism of health promotion in the workplace arose because of the work of an organization co-operating with employers and employees to reduce addiction problems. In one sense the project was supportive in that it offered a service to employees whose working life was already suffering because of an addiction problem. In another sense it could be interpreted as using 'healthism' as an industrial relations weapon, since the ultimate threat was to shape-up or be sacked. The political implications of this kind of 'healthism' in the workplace would not escape the attention of workers' unions in countries which are more highly unionized. Conrad (1990:499) summarized the issue: "The crucial question is, are corporations able to represent the individual's authentic interests in work and private life?"

An important conclusion of this study is that the distribution of health information is often viewed as highly political: Unions resent invasion of privacy in the work setting; employers de-bar discussion of occupational health issues; and women's groups (as in Eire) are placed under legal injunction not to distribute information about abortion. For this reason alone it is important to continue to encourage sources of health information other than establishment (government) health authorities.

So far this discussion has focussed on the print media which is distributed specifically to promote women's health. What also needs to be acknowledged is the role of newspapers, popular women's magazines and television serials such as Australia's "Country Practice". The popular press airs many issues of interest to women's health. However, it does so in a context which accepts the traditional role of women, advertises harmful products such as cigarettes and promotes foods which are often high in fats, salt and sugar.

Electronic media offer an alternative to the distribution of written material. Indeed, the two can be used in harmony as with the live teleconference on women's health issues run in 1988 by the Western Australian Women's Advisory Council through the auspices of the Western Australian College of Advanced Education, Media Department. The programme was supported by a folder of information about women's health services in the State. This combination provided immediate television feedback and follow-up material for on-going reference.

In Western Australia, the rural, commercial television channel, The Golden West Network, makes available, to the Western Australia College of Advanced Education, satellite air time for educational purposes. A component of these educational broadcasts includes the women's health issues series produced at the College (see Appendix 1). In this manner regional, rural and isolated women receive some exposure to women's issues. A similar arrangement has now been made with S.B.S., the Australian ethnic broadcasting service. Across the Pacific, in Vancouver, the Knowledge Network of the West also gives time to women's health issues and broadcasts National Film Board of Canada women's health material.

In Toronto an innovative programme to distribute health information through the non-print media was the Drug and Alcohol Information line. In 1988 this telephone service used an operator to direct callers to a relevant audio-cassette offering drug and alcohol information. The plan was to institute a direct dial service. This novel manner of distributing health information was developed by the Addiction Research Foundation (A.R.F.) which reported high rates of usage, particularly after they had advertised the service. The advantages of this programme are that it ensures anonymity and is easily accessible and available outside normal office hours.

There is, however, a cautionary tale which must be appended. In Perth, Western Australia, the private enterprise 0055 telephone information service includes anti-abortion information which is alarmist in nature. The local Pro-Choice group is currently investigating the matter. In other words, if direct-dial services prove to be a good way of distributing health information, what needs to be addressed is the nature, quality and intent of that information.

SCREENING AND PREVENTION

Preventative work in the form of cancer screening carries with it the same problems of lack of access that were identified during the discussion of health promotion. The solution to problems of access has been sought in mobile services. In Toronto a bus equipped with cancer screening equipment visits factories and community centres. The Liverpool (U.K.) Women's Health Bus is driven around the suburbs

offering crèche facilities downstairs and a meeting room upstairs. This service provides house-bound women, often young mothers, with the opportunity to meet for coffee, social interaction and health advice. Similarly, in London, the Lambeth Women and Children's Health Bus takes services to women rather than requiring women, with limited transport facilities, to come to them.

In Western Australia the tyranny of distance, which dictates so much in the lives of rural and isolated women, is being overcome by establishing mobile cancer screening clinics, currently on an experimental basis. In Perth and Toronto, women's health centres run work-site screening clinics, while in New Zealand, a nurse practitioner, operating from a women's health centre, visits farm women taking pap smears at home. Liverpool, in England, has implemented an age-related, city wide, cancer screening service for women.

In spite of these initiatives, universal screening for breast and cervical cancer is not accepted in all countries. In Denmark, routine mammography screening is currently under evaluation. In Norway, in February 1989, a consensus conference was held which decided to implement a mammography programme subject to research findings from Sweden.

Opposition to mammography screening has stemmed partly from potential risks in the screening procedures. Another concern lies in the false sense of security which arises from false negative results and anxiety emanating from false positive results. However, such problems should be avoidable in quality screening programmes which employ well-trained staff. Another objection arises from the high costs involved because, as noted in the Norwegian report (Backe 1989:164), there is still no decisive evidence about cure or prolonged survival rates:

At this point the panel cannot see that the utility of mass investigations with mammography justifies the considerable amount of money which the introduction of this method involves...It may also be relevant to discuss alternative costs i.e. the value of the possibilities lost by tying up resources in one activity. Perhaps more lives may be saved and more diseases combated if the money is used elsewhere. This is primarily a political question of priority.

In Eire, objections to universal screening are based on the utility of the results. In the opinion of one doctor, "the history of breast cancer treatment is marked by the stubborn refusal of generations of surgeons to admit that early cancer is not curable cancer, and even now there are surgeons who carry out needless mutilating operations." (Skrabanek 1988:129) With regard to cervical cancer screening, Dr. Skrabanek (1988:129) quoted a Lancet Editorial, which also questioned the value of screening: "Since cytological screening was introduced on a large scale around 1964, mortality has declined at 1 per cent a year; but this seems to be the rate at which it had been falling for several decades previously."

What is clear in the debate is that very little research has been completed on the efficacy of preventive screening. Dr Marsden Wagner, W.H.O. Regional (European) Office for Maternal and Child Health, endorsed this point very strongly: "As part of a European wide study of perinatal practices...it was found that only about 10% of the routine obstetrical practices have ever had sufficient, careful scientific scrutiny." (Wagner, unpublished copy)

Sad but true is the fact that the accuracy of screening results is often suspect. This is particularly so with pap tests. In California, laboratories were asked to tender to the government for the opportunity to check pap smears. A social action group ran a double blind test on the tendering laboratories and found that the cheapest was also the most inaccurate. In 1977, the Coalition for the Medical Rights of Women, San Francisco, published a booklet designed to counteract the problem of poor laboratory work, Choosing a Pap Smear Lab: A Guide for the Health Care Provider.

Ivan Illich (1976) argued that modern medicine has disempowered humankind. We cannot decide for ourselves if we are too sick to go to work - a medical opinion is required. Women seek to confirm their pregnancy with doctors instead of listening to the messages of their bodies. Annual check-ups create a perception that we need medical confirmation of wellness. Following on Illich's arguments, preventative screening would be seen as one more aspect of the medicalization of modern society. Marsden Wagner (unpublished paper) noted that routine health screening for children has been shown in both Sweden and the U.S.A. to make no difference to their health status except for the most high-risk groups.

There is, of course, little point to screening without adequate follow up. On Merseyside, the Liverpool Health Authority has implemented an extensive and thorough follow up and re-call service. However, this is atypical because: "The inadequacies of screening in England and Wales are well known. The management of positive smears in one study showed that 41 per cent of them were inadequately managed." (O'Connor 1988:130)

CONCLUSION

With regard to preventative work, the impression gained from this study is that screening is still inadequately researched or implemented. By contrast, women's health groups have done an enormous amount of work on health promotion. In particular, there is a lot of written women's health information and groups are still applying for funding to write more. On the one hand this could be interpreted as wasteful of limited resources. On the other hand it may be that in seemingly re-inventing the wheel and writing about issues which are already well covered, each local group of women is involving itself in an active learning process: "We discovered that you don't learn very much when you are a passive recipient of information. We found that each individual's response to information is valid and useful, and that by sharing our responses we can develop a base on which to be critical of what the experts tell us." (Boston Women's Health Book Collective 1971:3)

SECTION 7

WOMEN'S HEALTH RESEARCH

WOMEN'S HEALTH RESEARCH

Research on women's health has largely been conducted in the fields of social science and medicine. In both disciplines the informing paradigm has been scientific objectivity.

Just as ideologies inform process in the women's health movement, so too do they impinge upon research into women's health. Scientific objectivity has itself been put under the microscope by feminists who have criticized the narrow focus of objective, scientific studies as well as querying the extent to which it is possible to be objective. The social model of health has also broadened the base of what has traditionally been included in medical research; and empowerment philosophies have affected the process of research and its subject matter.

THE FEMINIST CRITIQUE OF OBJECTIVITY

Feminists have noted that in the name of science, nature has been split up, compartmentalized, dominated and exploited. Typically, Francis Bacon, who was partly responsible for creating the scientific mode of thinking, used rape as his central metaphor. What has resulted is a masculinist knowledge which emphasizes the cognitive and the objective. By contrast, the world of lived experience has been largely ignored. Feminists have sought to reinstate the validity of subjective experience as not something to be relegated to the mystical realm of nature:

A feminist epistemology derives from women's lived experience, centred on the domains of inter-connectedness and affectual relationality. It emphasises holism and harmonious relationships with nature, which is why feminism has links with that other major social movement of our time, ecology. (Mitchell and Oakley 1986:162-163)

As well as trying to change and expand the traditional paradigm of objectivity, feminists have queried the extent to which objectivity ever was objective. In the first place women have been largely ignored - treated as a sub-group. Rich (in Mitchell and Oakley 1986:74) felt that sexism was too weak a word to describe such exclusion: "It is really an intellectual defect, which might be named 'patrivincialism' or 'patriochialism': the assumption that women are a sub-group, that 'man's world' is the 'real' world." This being so, objectivity is reduced to male bias.

THE SOCIAL MODEL OF HEALTH AND RESEARCH

The parallels between compartmentalized, masculinist knowledge and the medical model of health are readily apparent. Within the medical model people become their disease; the body-part is cured. Furthermore, medicine has been 'patriochial', focussing on diseases which more often affect men. The social model of health, by contrast, is holistic, looking at the social and economic context and the person as a whole, as well as the biological cause and cure of a disease. As such the social model of health merges with the

interconnectedness of the feminist epistemology, acknowledging the inter-relatedness of the dimensions of women's lives.

EMPOWERMENT AND RESEARCH

Empowerment philosophies raise questions about how research money is spent: Why warheads rather than third world babies? Why heart disease and not breast cancer? As well as challenging the subject matter of research, empowerment philosophies also explore the possibilities of subject involvement in the research process.

An excellent example of an empowering research process is Project Aware in San Francisco. An objective of the research project was to empower prostitutes with knowledge about the transmission of AIDS. Prostitutes were involved in planning the project. Instead of using professional health educators, prostitutes were trained as communicators because, in the words of the project co-ordinator, "It may take some time for a health educator to become comfortable on the streets at midnight but it only takes a few minutes to convey the basic messages about AIDS transmission." HIV screening clinics for prostitutes were held in rooms in the hotels where they worked rather than in a hospital. At the end of 1988 it was becoming apparent to the researchers that the project had been instrumental in protecting workers in the sex industry and their clients from the spread of AIDS.

OBJECTIVITY/SUBJECTIVITY

The involvement of subjects in the research process has been advocated by epidemiologist, Dr Marsden Wagner (1987:2), because, "Involving the people who will use the data (including the health care providers and consumers) in the planning and conduct of research has been known for some time to increase the likelihood that the data will finally be used to change practices." Opposition to such a strategy usually emanates from concerns about objectivity. Dr. Wagner drew out the hidden agenda of such an argument:

We researchers are objective and therefore able to generate valid data and handle them reliably while providers and, most especially, consumers of health care, must be seen as subjective and therefore not to be trusted with the data. (Wagner 1987:3)

Wagner pursued his argument by pointing out that the "objective/subjective split goes back to ancient Greek philosophy and is deeply ingrained in our current thought." Descartes endorsed the view that "the only path to knowledge was objectivity and that we must ignore or control subjectivity. Now, thanks to Einstein and others, we understand that the existence of the observer cannot be excluded from any equation." (Wagner 1987:3) Wagner argued that objective researchers may never have been as objective as they would have wished and, further, that the subjective is important - a philosophy which lies at the core of the feminist critique of objective.

Subject involvement in the research process has been partially achieved through the funding of self-help groups. Many groups now conduct their own research or work to collate research on their special interest topic. The D.E.S. Action group in California has, for example, compiled a guide to The Reproductive Outcomes in Women Exposed Inutero to Diethylstilbestrol: A Review of the Literature 1978-1984.

THE IMPORTANCE OF SUBJECTIVITY

Feminism is predicated on the assumption that women are the authorities with regard to their own lives. Furthermore, personal experience is of significance, its validity drawn from the corroboration of shared experiences with other women. It is this point which feminists seek to raise in the context of social research for, in the past, it has been ignored. Helen Roberts (1985) noted that in early tests on the contraceptive pill, women's own experiences of headaches and loss of libido were dismissed as being too subjective.

Sari Tudiver, in Canada, endorsed the view that women's stories about the side effects of drug use and surgery are often lost in scientific studies:

They may be the women lost to follow-up, or dropped from a study because they complained of side-effects within the first three months, or part of the percentage of women who experienced "unusually" severe reactions to a drug. Yet the detail offered in their personal accounts is essential to a careful, scientific evaluation of the effects of a drug and to understanding the process of informed consent.
(Tudiver 1986:204)

THE UNFORTUNATE EXPERIMENT

What has become known as the 'Unfortunate Experiment' in New Zealand illustrates what can happen without subject involvement in the research process. For many years women with carcinoma in situ were left untreated by a senior gynaecologist at the National Women's Hospital in Auckland. His hypothesis was that carcinoma in situ was non-invasive. At no stage were the women informed that they were guinea-pigs in a research project. Some women subsequently died as a result of lack of treatment. Others were left physically maimed and carrying emotional scars arising from the manner in which their bodies and lives were treated.

The story was eventually exposed by Phillida Bunkle, a New Zealand sociologist, and Sandra Coney, a journalist. What is horrifying is that even those doctors who were opposed to the research were unable to get it stopped. It took the power of the media, and two women, to force a government inquiry which was reported by the New Zealand feminist journal Broadsheet (December 1987 and January 1988). The full story was eventually documented by Sandra Coney in her book The Unfortunate Experiment (1988) and canvassed by an Australian Broadcasting Commission's '4 Corners' (1988) documentary about the inquiry.

ETHICS, KNOWLEDGE AND CONSENT

The ethical issues of knowledge and consent are not isolated to the 'Unfortunate Experiment'. Juliette Mitchell (Mitchell and Oakley 1986:145-146) noted that about one in ten of British hospital patients are the subject of randomized trials, many without their knowledge or consent. Similar concerns about knowledge and consent have also been raised with regard to much of the experimental work being conducted in the area of reproductive technology. Anita Direcks, from the Dutch DES Action Group, noted the lack of information which surrounds the use of DES. There is, in fact, a long history of questionable ethics with regard to research in women's health dating back to the era "when J. Marion Sims, America's 'architect of the vagina', bought black, female slaves and housed them in a hut in his backyard in order to surgically experiment on them." (Oakley in Mitchell and Oakley 1986:138).

Juliette Mitchell made a connection between consent in research and treatment, pointing out that many professionals "contend that by and large it is no more necessary to ask for patient's consent to participate in research than it is to consult them about the ordinary treatment they will have." (Mitchell in Mitchell and Oakley 1986:145-146)

The issue of consent was paramount in the minds of many Australian women when it became apparent that, in Tasmania, women under anaesthetic were being used to train medical students in the art of internal pelvic examination - once again without the knowledge and consent of the woman. These concerns, also emerged in the community survey conducted by the Royal Women's Hospital in Melbourne:

The issue of consent and its relation to information was frequently raised by women consulted. Many women felt that their consent had not been satisfactorily obtained - before treatment in either the obstetric or gynaecology area; before a pelvic examination was performed; before a student was present during an examination or during an interview; or before a student performed an examination (whilst a woman is conscious, or when under anaesthetic). (McCarthy 1987:14)

THE PURPOSE OF RESEARCH

W.H.O. epidemiologist, Marsden Wagner (1987:1), fears that "as researchers we are more concerned with advancing ourselves and our profession than with improving services." He used the DES saga to highlight the gap between knowledge and practice: "the greatest tragedy ... is the continued use of the drug for many years after the association with cancer was published." (Wagner 1987:2) The problem of the gap between research data and medical practice continues today: "routine repeat Caesarean section is still practiced in some places in spite of knowledge that, in most cases, vaginal birth should be tried." (Wagner 1987:2)

In many cases the purpose of research is profitability. Drug testing is funded by pharmaceutical companies. So too is marketing: "A survey in the United States showed that the most important source of new medical knowledge among practising physicians in that country is the salesmen [sic] from the pharmaceutical firms. In the Federal Republic of Germany, there is one pharmaceutical salesman for every two practising physicians." (Wagner 1987:1)

Even when drug research is tendered out to university research centres, there is still a suspected connection between funding and research outcome. The problem lies in the threat to the traditional academic freedom of universities which will become increasingly compromised as they become more entrepreneurial in their quest for private enterprise research funds. However, academic freedom per se offers no guarantees against flawed research.

GOVERNMENT FUNDED RESEARCH

National and international government funding offers some independence of research outcome. Typical of what can be achieved in this context is the W.H.O. report, Having a Baby in Europe (1985), which documented pregnancy and childbirth services in Europe and recommended that:

1. the medical and social model of health be united to further develop pregnancy and birth services;
2. scientific evaluation be applied to all services; and
3. women's role in defining their own their needs be increased.

If government funding provides some independence in the research process how can governments themselves be monitored? The Health Issues Centre in Melbourne is an excellent example of a consumer oriented, government watchdog organization. It publishes a regular journal entitled Health Issues, sometimes eclectic in nature and sometimes devoted to a single issue. Entirely based on researching health issues, the centre is impressive in the speed and depth of its response to policy and budgetary changes.

Government departments, such as the New Zealand Health Services Research and Development Unit, make their own contribution to health research. As consciousness changes and as more women win senior postings then more research on women will emerge. The New Zealand unit is headed by a women, Dr Judith Johnstone. She chaired the New Zealand inquiry into women's health and, under her auspices, women's health research reports have been published, including, Women's Health in New Zealand: A statistical Overview (Bunnell 1987); and Women's Health Research in New Zealand 1976-1986: A Bibliography.

Governments are becoming more aware of women's voting power and are establishing organizations designed to research and collate data on women's lives, for example, the Office of the Status of Women, Canberra, the NAVF'S Secretariat for Women and Research in Oslo, and the Danish Council for Scientific Policy and Planning, Women's Studies Commission, which has produced a booklet entitled Women's Studies and Feminist Research in Denmark.

SOCIAL ACTION RESEARCH

Social action research renders the research outcome accountable in the real world. It is model of research which was clearly enunciated by Mao Tse Tung (Mitchell and Oakley 1986:162):

If you want knowledge you must take part in changing reality. If you want to know the taste of a pear you must change the pear, taking it into your mouth and chewing it. If you want to know the structure and properties of an atom, you must make physical and chemical experiments to change the state of an atom. If you want to know the theory and methods of revolution, you must take part in revolution.

The problem in the women's health movement is that many women who are taking part in the revolution have very little time to record their experiences. Some centres, as in Plymouth, New England, allocate a research role. It is a useful model. Study leave would also assist were it more readily available to women's health workers.

An example of a social action research project, which was clearly grounded in the development of a women's clinic, may be found at the psychiatric department of Toronto Western Hospital. Specialized women's services were developed and evaluated. The preliminary findings (Borins 1987) identified the women's clinic as a successful model for the initiation of similar services elsewhere.

NON-TRADITIONAL RESEARCH

There are many women's health issues which are simply unsuited to traditional research methods. It is difficult to develop and effectively administer questionnaires on subjects such as domestic violence, incest and rape. For these issues phone-ins have been used to gather some information. Search conferences have also been used to identify problems and to develop solutions. In Eire, for example, a Women's Health Week in 1986 inspired five major conferences in Dublin and many more around the country resulting in a nationwide report entitled, Get Healthy - Stay Healthy. (Minister of State for Women's Affairs, 1986). Similarly, in Australia, a regional overview of women's health needs and services was partially carried out through the "Darn Good Yarns" series - 17 two-hour discussion sessions held at varying times of the day to accommodate the needs of women. The outcome, A Stitch in Time (The Women's Health Research Project, Loddon Campaspe, 1988) was a comprehensive report recommending the development of a women's health service in the local area.

In general, the emphasis has swung away from quantitative research towards qualitative studies which reveal a depth of information which goes beyond statistical data. However, for policy purposes statistical data continues to be a useful basis of persuasion since it is hard for policy makers to ignore 'hard facts' such as those outlined in Hauora, Maori Standards of Health, which illustrates a poor standard of health in the Maori community of New Zealand.

INTERCONNECTED LIVES AND RESEARCH

Qualitative studies have documented women's thoughts and revealed the interconnectedness of their lives. Women's well-being reflects their economic status, gender role expectations, and physical and emotional status. This being so, women's health research must include reference to the social context of health. One study which has done this is Women and Poverty, a Review of the Statistics on Low Pay, Social Welfare and the Health Status of Irish Women, 1988 (Byrne, 1988). In similar vein, another Irish study, Women Together Against Poverty, The Experience of Travelling Women and Settled Women in the Community (Daly, 1988:40), noted the impact of poverty on health:

Women's health was felt to be endangered in many ways by poverty. Lack of money means a poor diet and unhealthy living conditions for the entire family. These create health problems in themselves. In many cases, however, female health problems are worsened by the fact that women are taught to put everybody's welfare before their own.

The issue is: Who takes care of the nurturer? Many women become tired and exhausted from over-work. In the past they have either not visited a doctor or, if they have done so, have been offered medical solutions for what are social problems. In this context, the issue of fatigue is now emerging internationally as a research topic.

EMERGING RESEARCH TOPICS

What became apparent in this study was the fact that many researcher are beginning to focus on the issue of stress and fatigue among women. However, the nature of the problem seems to escape definition. In Australia, 'Myalgic Encephalomyelitis' (M.E.) is identified by chronic arthritis or joint pains, muscle pain and chronic fatigue. Such symptoms are often dismissed as being psychological in origin. However, one psychiatrist noted that what he observed, in two early cases referred to him for assessment, was that

these women had always coped quite satisfactorily with their life and yet for some reason they had stopped coping...they weren't particularly depressed...they didn't have classic severe anxiety disorder and panic disorder. They really didn't fit in the psychiatric categories. (Bowman 1988:1)

In the U.S.A. a similar phenomenon 'Fibro Myalgia Syndrome' has been identified as causing chronic pain and fatigue. The difference between this and M.E. seems to be one of terminology.

Problems of terminology were identified by Dr Adele Thomas in her report sponsored by the West Australian Women's Fellowship. Her comparative study of upper-limb overuse syndromes revealed:

The extent and seriousness of upper limb overuse disabilities in the U.S.A.,... is contrary to the impression that the Australian media has given us. The difference between the three countries compared is in terminology - not the prevalence or cost of Occupational Overuse Syndrome to industry and government in these countries. (Thomas 1988:1)

MEDICALIZING SOCIAL PROBLEMS

In identifying disparate symptoms under one syndrome the risk is that the phenomenon may exist more in the definition than in reality. This possibility has been raised in connection with pre-menstrual syndrome:

Hilary Allen (1984) illustrates this point by suggesting that we might "pose the category of 'pre-breakfast syndrome' in which to lump together all the various complaints which could ever, in any individual, be shown to appear regularly in the first hours after waking and then to subside. These could include such diverse problems as habitual hangover, morning sickness, smoker's cough, lethargy or excitability, reduced or increased libido...(Vancouver Women's health collective, N.D.)

Eclectic syndromes may include social and biological phenomena. Whilst these embrace the need for interconnectedness in women's health research there is also the danger that medical solutions may be sought for social problems - more properly dealt with in the social arena.

THE RANGE OF WOMEN'S HEALTH RESEARCH

Research about women and their health has increased as feminist consciousness has entered universities and government departments. Indeed, in Norway there is now a feminist 'Women's University'. Research foundations such as Melbourne's 'Key Centre for Excellence for Women's Health in Society' may serve to attract more funds for research, although there will be a need for caution should this be pharmaceutical companies emerge as a major source of research funds.

Some women's health issues are reasonably well researched. In Eire, for example, there has been a national survey of breast feeding practice. Smoking among Irish women has been studied by Joyce O'Connor and Mary Daly and reported in their book, The Smoking Habit (1985). Epidemiological studies on breast cancer are being conducted in Norway. For all this, however, some issues remain poorly researched. Wagner (1988:1) noted that:

As part of a European wide study of perinatal practices, the Regional Office of Europe of the World Health Organization...found that only about 10% of the routine obstetrical practice had ever had sufficient careful scientific scrutiny.

Australian research on childbirth services has taken a step forward with the 1990 Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia. However, the fear is that little has been done to tackle the recommendations contained in the report, thus raising the problem that research can be used to divert attention from the real issue of implementing change.

Abortion is illegal in many states and countries. It has, therefore, received little epidemiological attention. In any case, there are definitional problems in researching illegal procedures because subterfuge terminology obscures the real scope of the issue. Despite the difficulties useful studies on abortion include: Luce Harnois (Ed.) Rapport de Recherche Sur L'Avortement au Quebec, and Dr Judy Straton's Abortion in Western Australia, 1985.

The health of lesbian women is little understood. To what extent, for example, are sexually transmitted diseases an issue for lesbians? What are the stresses for lesbians in being open about their life style (stress of visibility)? What are the maternity options for lesbian women? What is their level of substance abuse? What are the legal and emotional implications of hospital procedures which define 'next of kin' without reference to the partner in a lesbian relationship?

CONCLUSION

The ideologies which inform the women's health movement provide a critique of traditional research and have led to some innovative research projects such as Project Aware in San Francisco. Reports emerging on a world-wide basis reveal that a considerable amount of data is now available. The aim must be to use it for the betterment of women's lives. However, the jig-saw of knowledge about women's health is far from complete and contains significant gaps.

SECTION 8

IMPLICATIONS FOR TEACHING

IMPLICATIONS FOR TEACHING

One of the objectives of this study was to exchange ideas with academics and workers in the field of women's health in order to apply the experiences to the development of women's health courses at Edith Cowan University. In this section, then, women's health teaching refers to university courses and not to the broader sphere of women's health promotion in the community.

WOMEN'S STUDIES AS A SPECIALIST FIELD

The first conclusion of the study is that since women are a numerical majority in Western populations then women's issues should comprise more than half of all teaching that takes place. This does not happen, partly because men dominate academia and partly because the generation of knowledge has, traditionally, been male oriented. Moreover, the very language we use structures discourse to male paradigms. Dale Spender (1975, 1982, 1985) has extensively researched gender issues in language use and classroom interaction, and clearly demonstrated the exclusion from the educational process of women and women's ideas. This being so there is a strong case for the continuation of women's studies as separate and distinct courses within educational institutions.

As things stand women's health courses are variously located in tertiary institutions, though there is a tendency to teach them in social and behavioural science faculties in order to emphasize the importance of the social, rather than medical, model of health.

RESOURCES FOR DEVELOPING WOMEN'S HEALTH COURSES

Sheryl Ruzek, Virginia Olesen and Adele Clarke, Directors of the Women, Health and Healing Program, University of California, San Francisco, have collated and published (1986) fourteen course outlines on women's health. This excellent collection includes course titles such as: Feminist Perspectives on Women's Health; Women's Roles in Health and Healing Systems; Older Women and Their Health; Socio-Historical Issues in Women's Health; Comparative Perspectives on Women's Health Over the Life-Cycle; and Policy Issues in Women's Health Care. Fully referenced, with assignment and teaching outlines, this book is an excellent resource for anyone developing women's health courses.

A second book (Clarke *et al.* 1986) developed by the Directors of the Women Health and Healing Program provides additional resources and a philosophical base for the development of women's health courses featuring topics such as, "Teaching Women's Health: Constraints, Commitments, Resources and Trade Offs"; and "Integrating Minority Women's Health Into the Curriculum".

The work of Clarke, Olesen and Ruzek illustrates a number of key issues: The first is that the teaching of women's health is almost indefinitely divisible; the second is that within any specialism in women's studies there are continuities, parallels and apparent overlap which reflect the interconnected nature of women's lives; the third is that many of the issues taught in women's health

courses are sensitive and require teaching methods and assessment procedures which may not fit the traditional constraints of academia.

THE RANGE OF CONTENT

The seemingly endless divisibility of issues results from the ideologies which underpin the women's health movement. The feminist focus on women, and the implications of the social model of health, lead to the conclusion that all aspects of women's lives could reasonably be incorporated into the content of a women's health course, for example: women at home; women in paid employment; black women; rural women, young women; old women; and women of different social classes... sub-divided into health concerns such as menopause, depression, exercise, substance use and abuse.

The range of issues which it is possible to teach in a women's health course is enormous. To adopt an issues approach - for example: childbirth, reproductive technology, menopause, et cetera would be to start a list without end. In the unit taught at Edith Cowan University students are allowed to choose their own issues while class work pursues theoretical and analytical themes applicable across health issues. The theoretical analysis of women's health issues reveals many countinuties which provide a meaningful basis for course development. In California, Sheryl Ruzek (1986:87) has reached the same conclusion:

My third objective, to prepare students to assess the structural and social psychological forces involved in women's health across health issues, is critical. I underscore across health issues... I fear that with the trend towards specialization, it is too easy for a student to say, "Gee, I know about domestic violence, rape and abortion, but I don't know anything about drugs and sexual harassment or hazards in the workplace"... What I try to cultivate in students is an ability to cut across the substantive issues and deal with the underlying social, psychological, and structural issues, so that they indeed can develop an informed opinion or perspective on virtually any women's health issue.

In the health education unit taught at Edith Cowan University students are taught the fundamental philosophies of the women's health movement: feminism, the social model of health and empowerment. A range of substantive issues is introduced to illustrate particular points. The particular women's health issue is itself secondary. The analysis is of primary importance.

Although theoretical analysis establishes links and continuities across women's health issues, in society at large the focus is on distinct and specialist concerns. For this reason it is appropriate for universities to develop some degree of specialism in order to attract research funds and generate knowledge. For example, Robin Rowlands and Renata Klein, at Deakin University, in Australia, have built up a strong research profile and high level of expertise on reproductive technology.

IMPLICATIONS FOR EDITH COWAN UNIVERSITY

The specific courses which do emerge within the university will depend partly on the expertise of staff and partly on the teaching context. At Edith Cowan University the post-graduate course in women's studies offers wider social, theoretical and policy perspectives which might then be assumed to be understood by the students in the development of women's health courses. However, difficulties arise when students enter a women's health unit from a background other than women's studies. The solution might be to continue teaching the existing third year unit (see Appendix 3) in a manner which introduces the background theory and philosophy of the women's health movement, and to develop an additional unit at post-graduate level to apply those perspectives to substantive women's health issues.

TEACHING SENSITIVE ISSUES

Sensitivity in women's health courses emerges in two guises. Firstly, many women are attracted to women's health courses because they have been personally affected by one or more of the issues dealt with in the course, for example, incest. Sensitivity in this sense means acknowledging the validity of their experience. Secondly, the need for sensitivity can arise from controversy - from matters of political and feminist consciousness, like abortion, which are inherently difficult to debate: "No topic is more sensitive or difficult to deal with in the classroom than abortion. Proponents and opponents of abortion are deeply committed to their positions." (Ruzek 1986:84)

Since the validity of experience lies at the heart of feminism it is important to acknowledge personal experience in the teaching and learning process. However, there must be prior clarification of goals and objectives lest an academic unit of study becomes a group therapy session. Group therapy normally draws together people with a similar concern who are guided in their deliberations by a trained counsellor or by someone who has a similar background. These conditions do not, necessarily, prevail in the classroom. It is important, therefore, clearly to establish the unit's purpose and objectives at the start of a course.

Sheryl Ruzek (1986:84) stressed the importance of establishing objectives which connect personal issues to the wider socio-cultural context so as to diffuse the possibility of academic study becoming overly personalized. In women's health study groups at Edith Cowan University personal need is openly discussed in the first session during which a group contract is negotiated to establish an agreed upon tone for the group and to verify the units objectives. Three basic questions are addressed:

1. What do I want from this group?
2. What don't I want from this group?
3. What can I offer this group?

The collective responses are typed up and distributed for discussion at the next class.

Sensitivity is required in teaching any controversial subject. Much of this teaching may be done through a values clarification approach. Values clarification seeks not only to make clear existing opinions but to connect them with wider theoretical and social concerns. When dealing with sensitive issues empathy is an important component of the teaching strategy. This can be achieved by using case studies, visiting speakers or relevant videos. For example, the National Film Board of Canada's production "To a Safer Place" brings its audience to an empathetic understanding of incest from which point the wider issues of power and politics may be explored.

It is necessary for teachers of women's health to be informed about local services so that they can refer students who do begin to face issues in their own lives. However it is not impossible for students to work through personal issues whilst still meeting the academic objectives of the course. In the women's health issues unit taught at Edith Cowan University, students are given the option of following one issue in depth through three compulsory assignments. They may choose an issue which directly concerns them and in so doing come to a better understanding of themselves.

MEDICAL TRAINING

The relative merits of separate and generic services is a theme which has run throughout this report. Separate women's health services answer women's needs and provide innovative organizational and service models for conventional health care. However, the messages of the women's health movement have had little impact on mainstream services which raises concerns about the need to teach women's health issues as a component in medical training.

An ideology which considers professionals and clients as peers, and which values personal experience, calls into question traditional models of medical training. Many women's health centres have tried to re-direct the training of medical students by providing a venue for practicums and by offering guest lecturers to medical faculties. These moves are now becoming more formalized. The Family Planning Association in Perth, for example, has called for volunteers to train in the appropriate techniques for pelvic examination so that they may act as clients for training doctors. The Panum Institute in Copenhagen has a lectureship devoted entirely to women's health. The medical faculty at Melbourne University has a research institute - the 'Key Centre for Excellence for Women's Health in Society' - which has a training function. In these examples it can be seen that the ideals of the women's health movement may have begun to influence medical training.

In Australia, the Royal Australian College of General Practitioners has developed a course of advanced training in women's health. It "comprises three different yet integral components: a content of clinical practice, a process of consultation and an underlying philosophy towards health care delivery." (Ward et al. 1989:18) The course requires: one week's full time study; practical attachments and field work; attendance at additional education

sessions such as the Family Planning certificate course; the completion of a Pap smear audit to determine the frequency and quality of cervical cancer screening provided to a random sample of 50 women; and the completion of a personal study, a project and two written take-home examinations.

Of great importance in the success of this programme will be the practicums in women's health centres because values education is as much a part of medical training as the acquisition of medical knowledge. The collective nature and feminist philosophy of women's health organizations provide an alternative setting in which to develop among health professionals values appropriate for working with women. The importance of removing training from traditional settings has already been noted in the education of midwives in Holland. There midwives train for three years at Midwives' Colleges. The midwives do not undergo hospital based training in which there is a good chance that they will learn a subservient role. The autonomy of Dutch midwives and the success of the homebirth movement is partly due to the independent setting of midwifery education.

CONCLUSION

The continuation of a separatist stance in the development of alternative women's health care and women's health courses in universities will create an on-going, innovative critique of mainstream services. However, the point is to blend theory with practice. Without more dialogue with mainstream medical training programmes, many of the valuable messages of the women's health movement will be lost.

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APPENDIX 1

WOMEN'S HEALTH ISSUES VIDEOTAPE SERIES

The Western Australian College of Advanced Education has developed a series of videotapes on women's health issues. Devised by a lecturer in the Department of Health Studies, Lynne Hunt, the series features interviews with Western Australian professionals and self-help groups.

The underlying philosophy of the series is empowerment. The programmes offer health information, self-help strategies, examples of resources in the area of women's health and models for social action.

The programmes are pitched at a level suitable for broadcasting to the general public. They will, therefore, be useful to self-help groups and community health educators. Topics relevant to young women, for example, the teenage pregnancy series, are appropriate for school use as well as youth and community work. Some of the tapes have already been used in hospital work by both social workers and clinic staff.

VIDEOTAPE 1

THE TEENAGE PREGNANCY TAPE

Programme 1. 'Teenage Pregnancy - Feelings and Reaction' 11' 32"

A 16 year old with a young baby and a 15 year old girl, who is eight months pregnant, discuss the problems and difficulties of their situation and the personal development aspects of young motherhood.

Programme 2. 'She's Pregnant - What Can She Do Now?' 52' 30"

The issue is informed choice. The programme features a smorgasboard of the professional resources available to pregnant teenagers. For Western Australians the video serves to access those resources. For viewers outside the state the range of agencies discussed serves as a model of the resources needed to support young women in their unplanned or unwanted pregnancies.

Programme 3. 'Parents of Adolescent Mothers' 13' 17"

Parents who remain supportive of their pregnant teenager may themselves need help. In this interview one mother of a pregnant teenager explores the feelings, reaction and actions which ultimately led to the development of a support group: Parents of Adolescent Mothers.

Programme 4. 'Adoption - the Options' 18' 36"
Sue Midford from the Adoption Research and Counselling Service in Perth discusses the issue of adoption with two young women: one who considered adoption but kept her baby, the other a relinquishing mother who is happy with her decision to have her baby adopted.

Inclusive cost for four programmes A\$75

VIDEOTAPE 2 PRE-MENSTRUAL SYNDROME

Programme 1. 'Pre-Menstrual Syndrome - A Medical View' 11' 07"

A doctor from the Women's Health Care House in Perth and Dr Judy Edwards, Doctor's Reform Society, discuss symptoms, solutions and perspectives on the pre-menstrual syndrome.

Programme 2. 'Pre-Menstrual Syndrome - A Personal View' 12' 51"

Denise Kelly, founding member of the PMS support group in Perth, outlines what PMS means to her and discusses the importance of self-help groups.

Inclusive cost for two programmes A\$45

VIDEOTAPE 3 THE MENOPAUSE TAPE

Programme 1. 'Menopause - The Medical View' 16, 08"

A doctor from the Menopause Clinic in Perth discusses symptoms, medical solutions and self-help strategies and analyses menopause in the context of the lifestyle of western women.

Programme 2. 'Looking After Yourself - Diet and Emotional Care' 24' 15"

Personal health care issues for women before, during and after the menopause. High calcium and low fat diets are discussed with a professional dietician. Emotional care and a positive outlook on life are featured in an interview with a former counsellor from the menopause clinic.

Programme 3. 'Looking After Yourself - Pelvic Floor Exercises' 30' 31"

The importance of pelvic floor exercises is outlined by a physiotherapist who also carefully explains how to do the exercises.

Inclusive cost for three programmes A\$60.

VIDEOTAPE 4 SEXUAL ASSAULT

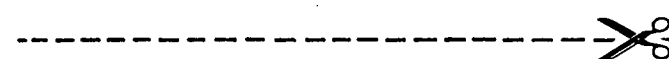
Programme 1. 'Sexual Assault Referral Centre' 14' 05"

A counsellor and doctor from the Perth S.A.R.C. discuss the work of the centre and dispel many of the public myths about rape.

Programme 2. 'Establishing Rural Sexual Assault Referral Centres' 9' 22"

This programme presents a model for social action which is particularly useful for rural women. Kaye Lake, from Geraldton, Western Australia, outlines the process involved in developing a rural Sexual Assault Referral Centre.

Inclusive cost for two programmes A\$45.



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APPENDIX 2

AGENCIES CONTACTED IN THE STUDY

AUSTRALIA

Adelaide Women's Community Health Centre, South Australia
 Dale Street Women's Health Centre, South Australia
 Elizabeth Women's Community Health Centre, South Australia
 Working Women's Centre, Adelaide, South Australia
 Women's Health Resource Collective, Melbourne, Victoria
 Women's Health Information Service, Melbourne, Victoria
 Health Issues Centre, Melbourne, Victoria
 Key Centre for Women's Health in Society, Melbourne, Victoria
 HBA Shepherd Foundation, Melbourne, Victoria
 Westmeade Hospital, Sydney, New South Wales
 Royal Hospital for Women, Sydney, New South Wales
 Women's health in Industry, Sydney, New South Wales
 Liverpool Women's Health Centre, Sydney, New South Wales
 Brisbane Women's Health Centre, Queensland

NEW ZEALAND

Ministry of Women's Affairs, Wellington
 Research and Development Unit, New Zealand Board of Health,
 Wellington
 Women, Children and Family Programme, Wellington
 Women's Health Collective, Palmerston North
 Women's Health Centre, Dannevirke
 Broadsheet, Auckland
 Auckland Women's Health Centre
 Dr Grant, Auckland

U.S.A.

University of California Medical Center, San Francisco
 San Francisco State University, San Francisco
 D.E.S. Action, San Francisco
 Project Aware, San Francisco
 Boston Women's Health Book Collective, Boston
 Feminist Health Centre of Portsmouth, Mass.
 Cambridge Hospital, Cambridge Mass.

CANADA

Knowledge Network, Vancouver
 Vancouver Women's Health Collective
 National Film Board of Canada, Vancouver
 Studio D., National Film Board of Canada, Montreal
 Montreal Health Press.
 Centre de Sante des Femmes, Montreal
 Reproductive Outreach Worker, Klinik, Winnipeg
 Manitoba Council on International Co-operation, Winnipeg
 Women's Health Clinic, Winnipeg
 Immigrant Women's Health Centre, Toronto
 Addiction Research Foundation, Toronto
 Women's Clinic, Toronto
 International Council on Women's Health Issues, Halifax

ENGLAND

Multi-Ethnic Women's Health Project, London
 Women's Health and Reproductive Rights Information Centre, London
 N.C.E.T., London
 Interactive Video Centre, London
 Lambeth Health Bus, London
 Community Services Headquarters, Sefton General Hospital, Liverpool
 Health Science School, Liverpool Polytechnic
 Department of Sociology, Liverpool University
 Director of Community Education, Open University, Milton Keynes

EIRE

Health Promotion Unit, Department of Health, Dublin
 Catholic Marriage Advisory Service, Dublin
 Medical Women International, Dublin
 Dublin Well Women Centre
 Economic and Social Research Institute

HOLLAND

Midwives Practice, Amsterdam
 Dr Meijer, Amsterdam
 Women's Health Network on Reproductive Rights, Amsterdam
 Women's Health Centre, Amsterdam
 D.E.C. Aktiegroep, Utrecht

DENMARK

Regional Officer for Europe, Maternal and Child Health, W.H.O.,
 Copenhagen
 Institut for Social Medicin, Panum Instituttet, Copenhagen

NORWAY

Senter for Helse Adminstrasjon, Rikshospitalet, Oslo
 Secretariat for Women's Medical Research, Oslo
 Institute of General Practitioners, Oslo
 Institute of Social Medicine, Oslo
 Health Sister, Asker
 Epidemiologist, Tramsø University
 Women's University, Loten

THAILAND

Faculty of Sociology and Anthropology, Thammasat University, Bangkok

APPENDIX 3

UNIT OUTLINE: WOMEN'S HEALTH ISSUES

WOMEN'S HEALTH ISSUES 3213

LECTURER: LYNNE HUNT

UNIT OUTLINE

OBJECTIVES:

On completion of this unit, students will be able to:

1. Analyse current theories about the health status of women.
2. Utilize the theoretical knowledge of women's studies to promote the health of women.
3. Apply a variety of inquiry and research skills to the analysis of women's health status.
4. Develop practical resources, skills and strategies for working with women such as: networking, resourcing, accessing, empowerment and group work.
5. Work with socio-political structures to promote change which is beneficial to women's health.
6. Understand the biological and psychological dimensions of women's health.
7. Critically examine the construction of knowledge in the health field in order to understand its impact on women.
8. Evaluate health care programmes for women.

ASSESSMENT:SUBMISSION DATE

Essay	35%	Friday Week 5
Project 1	30%	Friday Week 10
Project 2	35%	Friday Week 15

DATE	CONTENT	TIMING
WEEK 1	1. INTRODUCTORY GAME	10'
	2. INTERVIEWING x 2	10'
	3. PERSONAL INTRODUCTIONS	20'
	4. CLASS DISCUSSION: ESTABLISHING A GROUP CONTRACT	20'
	BREAK	
	5. INTRODUCTION TO ASSESSMENT	15'
	6. VIDEO: 'OVERVIEW OF WOMEN'S HEALTH'	60'
	EXTENSION READING: TEXTBOOK CH. 1	
WEEK 2	1. STUDENT SUMMARY: EXTENSION READING WK 1	10'
	2. LECTURER: WHAT IS FEMINISM?	30'
	3. VIDEO EXCERPTS: 'ANDROGYNY'	15'
	'DE BEAUVOIR'	5'
	BREAK	
	4. SMALL GROUP DISCUSSION: APPLY FEMINIST PERSPECTIVE TO THE ISSUE OF P.M.S.	15'
	5. VIDEO: "WHAT PEOPLE ARE CALLING P.M.S."	30'
	6. CLASS DISCUSSION: "WHAT FEMINISM MEANS TO ME"	35'
	EXTENSION READING:	
	a) S. RUZEK 'FEMINIST VISIONS OF HEALTH' - AN INTERNATIONAL PERSPECTIVE	
	b) P.M.S. A FEMINIST PERSPECTIVE	
WEEK 3	1. STUDENT SUMMARY: EXTENSION READING WK 2	10'
	2. LECTURE: WHAT IS EMPOWERMENT?	35'
	3. SMALL GROUP DISCUSSION: EMPOWERING HOSPITAL PATIENTS	20'
	4. CLASS FEEDBACK	15'
	BREAK	
	5. LECTURE: NEW FORMS OF ORGANIZATION	40'
	6. VIDEO: 'WOMEN'S HEALTH CARE HOUSE'	15'
	EXTENSION READING: NETWORKING	
WEEK 4	1. LECTURE: SOCIAL ACTION	20'
	2. SMALL GROUP WORK: PLAN A CAMPAIGN	20'
	3. CLASS FEEDBACK	15'
	BREAK	
	4. SKILL: SUBMISSION WRITING	30'
	5. SKILL (OPTIONAL WORKSHOP): ESSAY WRITING	30'
	EXTENSION READING: INTERVIEWING WOMEN	

	1. LECTURE: RESEARCHING WOMEN'S HEALTH	40'
	2. VIDEO: "HOW TO LIE WITH STATISTICS"	15'
	BREAK	
WEEK 5	3. VIDEO: "ETHICS IN WOMEN'S HEALTH RESEARCH"	45'
	4. CLASS DISCUSSION: REACTIONS TO VIDEO	10'
	5. SKILL (OPTIONAL WORKSHOP): DEPTH INTERVIEWING	25'

	1. SNOWBALL: 5 CHANGES TO IMPROVE WOMEN'S HEALTH	
	2. LECTURE: WOMEN'S HEALTH PROMOTION	40'
	3. KIT: ACCESSING RESOURCES	5'
	BREAK	
WEEK 6	4. VIDEO: 'PROTECT YOURSELF, RESPECT YOURSELF'	5'
	5. CLASS DISCUSSION: HEALTH EDUCATION IN POLITICAL CONTEXT	15'
	6. LECTURE: THE CONCEPT OF WELLNESS	20'
	7. VIDEO: "IS IT HOT IN HERE?"	20'
	8. SKILL: RELAXATION	15'

EXTENSION READING: IDEOLOGY OF MOTHERHOOD

TWO WEEKS PRACTICUM - NO ATTENDANCE

ONE WEEK VACATION - NO ATTENDANCE

PUBLIC HOLIDAY

	1. FISHBOWL: REPRODUCTIVE TECHNOLOGY	20'
	2. SMALL GROUP DISCUSSION: QUESTIONS ON REPRODUCTIVE TECHNOLOGY	30'
WEEK 10	3. CLASS FEEDBACK:	10'
	BREAK	
	4. VIDEO: REPRODUCTIVE TECHNOLOGY	30'
	5. CLASS DISCUSSION: INFERTILITY AND THE IDEOLOGY OF MOTHERHOOD	40'
	6. MID-SEMESTER EVALUATION	5'

	1. VIDEO: 'TO A SAFER PLACE'	60'
	2. DE-BRIEFING	10'
	BREAK	
WEEK 11	3. GUEST SPEAKER: SEXUAL ASSAULT REFERRAL CENTRE	55'

EXTENSION READINGS: WOMEN AND SEXUALITY

WEEK 12	1. VIDEO: 'FEELING YES, FEELING NO'	40'
	2. DE-BRIEFING	15'
	BREAK	
	3. JIGSAW: WOMEN AND SEXUALITY	50'
	4. FILM: 'SIZE 10'	30'
EXTENSION READING: TEXTBOOK CH. 5		

WEEK 13	1. LECTURE: WOMEN'S HEALTH AND SOCIAL POLICY	30'
	2. VIDEO: ABORTION	15'
	3. FISHBOWL: ABORTION	20'
	4. CLASSROOM DISCUSSION: WOMEN AND POPULATION POLICY	15'
	5. CASE STUDY: SPORTS POLICY FOR WOMEN	25'
	6. VIDEO: 'MIRROR/MIRROR'	30'

WEEK 14	1. LECTURE: DEPENDANCY AND WOMEN	30'
	2. VIDEO: 'CO-DEPENDANCY'	30'
	BREAK	
	3. HEALTH SHARING: STUDENTS POOL IDEAS FROM THEIR CHOSEN TOPICS	75'
EXTENSION READINGS: DOMESTIC VIOLENCE		

WEEK 15	1. JIGSAW: DOMESTIC VIOLENCE	20'
	2. VIDEO/DISCUSSION: 'DOMESTIC VIOLENCE'	90'
	3. COURSE EVALUATION	25'

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DEPARTMENT OF HEALTH STUDIES

HST 3213 WOMEN'S HEALTH ISSUES

ASSESSMENT

Lecturer: Lynne Hunt

	<u>Word Length</u>	<u>Value</u>	<u>Submission Date</u>
ESSAY	1,750 - 2000	35%	Friday Week 5
PROJECT 1	1,750	30%	Friday Week 10
PROJECT 2	1,500	35%	Friday Week 15

In general students will be expected to complete all three pieces of assessment on the same topic in order to develop a depth of knowledge which is appropriate to a third year unit.

ESSAY TOPIC

Survey the literature on (your choice of topic). Show evidence from research about the issue, elaborate any controversies on the topic and identify how mainstream medicine and the Women's Health Movement have dealt with the issue.

PROJECTS

Students should choose two of the following projects.

- a) Depth interview
- b) Research design
- c) Health promotion project
- d) Agency profile
- e) Submission for funds
- f) Personal account of a woman's health issue.
- g) Your choice - please discuss with lecturer.

Students who feel that they would like to develop their essay skills further should read one of the following books:

Berry, R. (1969), How to Write a Research Paper, Pergamon, London.

Doubleday, N.F. (1971), Writing the Research Paper, D.C. Heath & Co., Lexington, Massachusetts.

Markham, R. & Waddell, M. (1971), 10 Steps in Writing the Research Paper, Woodbury, New York.

McEvedy, M. Rosanna and Jordan, Mike (1986), Succeeding at University and College, Nelson, Melbourne.

Phillips, G.R.E. and Hunt, L.J., (1975), Writing Essays and Dissertations, University of Western Australia Press, Nedlands.

GUIDELINES FOR PROJECTS

a) DEPTH INTERVIEW

1. The objective of this assignment is to compare two different views on your chosen women's health issue.
2. Using background knowledge from your essay formulate a list of approximately 10 depth interview questions. Note that the success of your interview depends on the quality of the questioning. It is, therefore, suggested that you do some reading on how to do depth interviews.
3. Select two interviewees..
4. Conduct the interview.
5. Write a research report which includes:
 - i. Cover sheet
 - ii. Contents page
 - iii. Introduction to person and topic, (1-2 paragraphs) - maintain confidentiality by excluding names.
 - iv. Specification of your objectives in the interview (1 paragraph)
 - v. List of questions (no more than 10)
 - vi. Results. Avoid writing a verbatim report but do include content and examples from the interviews to create a lively and journalistic overview.
 - vii. Conclusions. Note how the issues raised reflect broader concerns within the women's health movement.

SUGGESTED REFERENCES

Roberts, H. (ed) (1981), Doing Feminist Research, Routledge & Kegan Paul, London.

Wadsworth, Y. (1984), Do It Yourself Social Research, Victorian Council of Social Services, Melbourne.

b) RESEARCH DESIGN

- 1) Identify problems and sub-problems.
- 2) Define concepts. Show evidence of reading on how previous researchers have defined the concepts and from this derive your own working definitions.
- 3) Show exactly how to select a study population for your topic.
- 4) Design a measuring instrument (e.g. questionnaire, depth interview, search seminar) which will give answers to your problems and sub-problems.
- 5) Identify a pilot study group of four people and pilot the measuring instrument.
- 6) Write a detailed evaluation of the measuring instrument and re-write it in final form with the necessary changes to overcome the problems identified by the pilot study.
- 7) Show how you will present results - this section requires you to actually draw up the blank tables showing cross tabulations where necessary or to show how you will draw information out of verbatim reports derived from depth interviews and search seminars.

c) HEALTH PROMOTION PROJECT

1. Identify a target group (could be health professionals or health consumers)
2. Develop a detailed plan for a 3 hour workshop.

Show:

 - (i) Teaching and learning objectives.
 - (ii) Target group and size of group.
 - (iii) Setting.
 - (iv) Plan, with exact timing (show ice-breaking and group trust activities).
 - (v) Background philosophy to plan.
 - (vi) Show, in detail, teaching and learning resources, e.g., fact sheet, role play scenarios, questions for group discussion.
 - (vii) List of reading resources.
 - (viii) Follow up activities for participants.
 - (ix) Evaluation sheet.

d) AGENCY PROFILE (SEE LECTURER TO ARRANGE ACCESS TO AGENCY)

Through brief interviews, observation and analysis of the literature produced by your chosen agency, write up a report of the agency which incorporates:

1. Agency objectives.
2. Staffing profile.
3. Philosophy.
4. Clients (how many, gender, residential area, ethnicity etc.).
5. Programmes
6. Funding.
7. Evaluation procedures.
8. Future directions.

e) SUBMISSION FOR FUNDS

Draw up a submission for funding a service for your women's health issue. To make this exercise realistic you may be able to work with a community group. Notes on submission writing will be given in class.

f) PERSONAL VIEW OF WOMEN'S HEALTH ISSUE

Write up your own experiences of a woman's health issue. Write in essay style but use the first person. The essay should be divided into two equal parts, the first showing a personal overview and the second analysing how your story highlights aspects of the women's health movement. The second part of the essay must include evidence of reading.

EDITH COWAN UNIVERSITY

CENTRE FOR THE DEVELOPMENT OF HUMAN RESOURCES**TECHNICAL REPORTS**

1. Smith, P. (1987). **Conference on English Language Report**. (Technical Report No 1.). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «Not available»
2. Knowles, J. (1987). **Ethnicity Discussion Paper**. (Technical Report No 2, 21pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «Available on loan only»
3. Roche, V. (1987). **Lefroy Hostel Staff Training Report**. (Technical Report No 3, 17pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «\$3.00»
4. Underwood, R. (1988). **Normalization Training Project : An Evaluation Study**. (Technical Report No 4, 48pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «\$5.00»
5. Cocks, E. (1988). **Final Report : Normalization Training Project - 1987**. (Technical Report No 5, 40pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «\$4.00»
6. Grant, J. (1988). **The Review of Organisational Functioning for the South Perth Library Service**. (Technical Report No 6, 12pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «Not available»
7. Saggars, S. (1988). **Cross-Cultural Training in the Department for Community Services**. (Technical Report No 7, 43pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «\$5.00»
8. Roche, V., & Cocks, E. (1988). **Meeting the Needs of Elderly People with Impairments**. (Technical Report No 8, 34pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «\$4.00»
9. Stehlik, D., & Underwood, R. (1988). **A Training Program for HACC Coordinators**. (Technical Report No 9, 59pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «\$5.00»
10. Cocks, E., Wills, D., & Croft, J. (1988). **Program Development Workshop : Needs, Strategies and Future Directions of the Family Support Program. A Workshop Training Manual**. (Technical Report No 10, 39pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. «Available on loan only»

11. Emmett, M., Pielage, S., Wiles, D., & Williams, A. (1988). **Services for the Ethnic Aged in Perth - An Exploratory Study.** (Technical Report No 11, 18pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$3.00>
12. Wiles, D., & Brienne, J. [Eds] (1989). **"If only I had....." : Final Report of a Social Survey of the Needs of Older Adults living in the City of Nedlands.** (Technical Report No 12, 41pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$5.00>
13. Underwood, R. (1989). **An Evaluation of the Programme Development Workshop for the WA Family Support Programme.** (Technical Report No 13, 84pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <Available on loan only>
14. Cocks, E. (1989). **Collection of Source Material on a Critique of Predominant Bureaucratic, Professional and Technological Human Service Models and Some Alternative Approaches.** (Technical Report No 14, 154pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <Available on loan only>
15. Underwood, R., & Sheridan, B. (1989). **Information Technology in Youth Agencies : A Rural Perspective.** (Technical Report No 15, 33pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$4.00>
16. Wiles, D. [Ed] (1989). **Perspectives on Income, Accommodation, and Services for the Aged : Proceedings of the WACOTA Forum held for Seniors' Week on Thursday 13 April 1989.** (Technical Report No 16, 50pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$5.00>
17. Tomlins, R., & Wiles, D. (1990). **Ageing in Bayswater : A Report of a Social Survey conducted amongst those Aged 60 Years and Over.** (Technical Report No 17, 73pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$7.50>
18. Cocks, E., & Jackson, R. (1990). **Critique of Predominant Human Service Models : A Set of Readings.** (Technical Report No 18, 193pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <Available on loan only>
19. Wiles, D., Ewers, W., Ho, E., & Olley, E. (1990). **Southcare Aged Needs Survey.** (Technical Report No 19, 48pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$5.00>
20. Underwood, R. (1990). **The Utilisation of Computers in Youth Agencies : Curriculum implications for a tertiary course in youth work.** (Technical Report No 20, 37pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$4.00>

21. Dixon, C., Underwood, R., & Eversden S. (1990). **Adult Learning : A Tertiary Programme in Christian Education for Volunteer Instructors.** (Technical Report No 21, 24pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$3.00>
22. Carr, J., & Colyer, S. (1990). **Computers in Recreation and Sport Management.** (Technical Report No 22, 26pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$3.00>
23. Wiles, D. [Ed] (1990). **Advances in Aged Care : Papers for the WACOTA Forum held for Seniors' Week on Monday, 30 April 1990.** (Technical Report No 23, 29pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$3.00>
24. **
25. White, R., Omelczuk, S., & Underwood, R. (1990). **Youth Work Today : A Profile.** (Technical Report No. 25, 48pp). Perth: Western Australian College of Advanced Education, Centre for the Development of Human Resources. <\$5.00>
26. Hunt, L. (1991). **Professional Experience Programme Report. Women's Health Promotion, an International Perspective.** (Technical Report No. 26, 111pp). Perth: Edith Cowan University, Centre for the Development of Human Resources. <\$10.00>